

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6023

CERTIFICATE OF DEATH

06020

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1652 Pin Oak Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>ELIZABETH</b> Last <b>ARTZ</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 59</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1890</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua E. Powles</b>				14. MOTHER'S MAIDEN NAME <b>Carrie R. Bikle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Claude Artz</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Coronary Thrombosis</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, Diabetes mellitus, Hypertension C-V-System</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown, Md</b>		(County)		(State)	
21. I certify that I attended the deceased from <b>May 11, 1956</b> to <b>May 13, 1959</b> , that I last saw the deceased alive on <b>May 13, 1959</b> , and that death occurred at <b>1:13 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dalton M. Welty</b> M.D.				ADDRESS (Street, city or town, state) <b>998 Poloma Ave</b>		DATE SIGNED <b>5-14-59</b>	
PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/15/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

# CERTIFICATE OF DEATH

6023

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased		John J. Smith	
Sex		Male	
Age		45	
Date of Birth		Jan 15, 1900	
Place of Birth		Boston, Mass.	
Cause of Death		Heart Disease	
Date of Death		Jan 20, 1945	
Place of Death		Boston, Mass.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Jan 25, 1945	
Place of Registration		Boston, Mass.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6024

CERTIFICATE OF DEATH

06021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b L $\frac{1}{2}$ YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 838 MARYLAND AVE.		d. STREET ADDRESS 1838 MARYLAND AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GARL NEWTON BATEMAN		4. DATE OF DEATH MAY 1 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY TENANT FARM	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM O. BATEMAN		14. MOTHER'S MAIDEN NAME MATILDA ANDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-14-6711	
17. INFORMANT MRS. SARAH H. BATEMAN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO pulmonary congestion (b) arteriosclerotic heart disease (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 19 59, that I last saw the deceased alive on May 1, 19 59, and that death occurred at 11 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Howard N. Weeks M.D.		136 North Potomac St. 5/4/59	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/4/59	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

CERTIFICATE OF DEATH

1968

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH 4-4-68		PLACE OF DEATH BALTIMORE, MARYLAND	
AGE 35		SEX MALE		RACE WHITE	
BIRTH DATE 12-15-32		BIRTH PLACE MOBILE, ALABAMA		EDUCATION HIGH SCHOOL	
OCCUPATION CONTRACTOR		MARRIAGE MARRIED		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS	
INTERVIEWED BY J. H. SMITH		DATE OF INTERVIEW 4-5-68		PLACE OF INTERVIEW HOME	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH	
DATE OF SIGNATURE 4-5-68		DATE OF SIGNATURE 4-5-68		DATE OF SIGNATURE 4-5-68	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06022

6025

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>50 Min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1 832 Chestnut St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl Beard</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3 1959</b>
9. AGE (In years last birthday) yrs. <b>50</b>		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wsh Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Conrad Edw Beard</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Rupenthal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Conrad E. Beard</b>		Address <b>832 Chestnut St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>750X</b> DUE TO <b>anoxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>anencephalic (monster)</b> DUE TO <b>(monster)</b> (c) <b>(monster)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3, 1959</b> to <b>May 3, 1959</b> , that I last saw the deceased alive on <b>May 3, 1959</b> , and that death occurred at <b>May 3, 1959</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		ADDRESS (Street, city or town, state) <b>156 N. Vicksburg St Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD N. WEEKS</b>		DATE SIGNED <b>5/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Dale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg Berkley Co W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

2081254XV3

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES M. BOND		45		M		W		10-15-68	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
BIRMINGHAM, ALA.		10-15-23		BIRMINGHAM, ALA.		10-15-68		10:00 AM	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY	
FARMER		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION	
PREVIOUS ILLNESS		TREATMENT		HOSPITAL		PHYSICIAN		NURSE	
NONE		NONE		NONE		DR. J. H. SMITH		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF MINISTER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

WESTLAND STATEMENT OF HEALTH - BIRMINGHAM, ALA.

## 6086 CERTIFICATE OF DEATH

06023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>89 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Smithsburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 E. Water St.</b>			d. STREET ADDRESS <b>15 E. Water St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First Elizabeth Middle Wyett Last Bell</b>			4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 59</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1869</b>		9. AGE (In years last birthday) yrs. <b>89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Md.</b>	
13. FATHER'S NAME <b>Lewis J. Bell</b>			14. MOTHER'S MAIDEN NAME <b>Charlotte Marbourg</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rev. Charles Bell, Smithsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <b>4-22</b> , 19 <b>59</b> , to <b>5-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4-22</b> , 19 <b>59</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Charles F. Hess M.D.</b>		ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b>		DATE SIGNED <b>5-11-59</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>X Scott F. Minnich &amp; Son, Smithsburg, Md.</b>			24a. REC'D BY REGISTRAR <b>MAY 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 100-100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		MEMPHIS, TENN.	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
APRIL 4, 1968		4:00 PM		MEMPHIS, TENN.		HEART DISEASE		SUICIDE	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF CHIEF OF BUREAU		19. SIGNATURE OF COMMISSIONER		20. SIGNATURE OF GOVERNOR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6026

## CERTIFICATE OF DEATH

06024

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>1140 Potomac St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SUSAN ELIZABETH BENDER</b>				4. DATE OF DEATH Month Day Year <b>May 27 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jany 20 1892</b>	
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis W. Stambaugh</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Tipton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Charles W. Stambaugh 5240 Noracissis Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Baltimore 15 Md. Arteriosclerotic Heart Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 4, 1959</b> , to <b>May 27, 1959</b> , that I last saw the deceased alive on <b>May 27, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 S Prospect St Hagerstown, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>R. S. Stauffer</b>		M.D. <b>145 S Prospect St Hagerstown, Md.</b>					
PHYSICIAN'S NAME (Type) <b>R. S. STAUFFER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1901

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES M. JONES		35		M		W		1866		BALTIMORE		MD		MD		MD		1901		BALTIMORE		MD		MD		MD	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S DEATH DATE		MOTHER'S DEATH DATE		FATHER'S DEATH PLACE		MOTHER'S DEATH PLACE	
JAMES M. JONES		MARY J. JONES		FARMER		HOUSEWIFE		METHODIST		METHODIST		HIGH SCHOOL		HIGH SCHOOL		MARRIED		MARRIED		1895		1900		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
HEART DISEASE		NATURAL		3 WEEKS		PAIN IN CHEST, SHORTNESS OF BREATH		MEDICINE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF GRAND JURY		SIGNATURE OF DISTRICT COURT		SIGNATURE OF CIRCULAR COURT		SIGNATURE OF OTHER	
J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES	

NOT FOR RECORD

THIS CERTIFICATE IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR ALTERED IN ANY MANNER. IT IS THE DUTY OF THE REGISTRAR TO PRESERVE THIS RECORD IN A SAFE AND SOUND MANNER. THE REGISTRAR IS NOT RESPONSIBLE FOR THE LOSS OF THIS RECORD OR FOR THE ALTERATION OF THIS RECORD IN ANY MANNER. THE REGISTRAR IS NOT RESPONSIBLE FOR THE LOSS OF THIS RECORD OR FOR THE ALTERATION OF THIS RECORD IN ANY MANNER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6027

CERTIFICATE OF DEATH

06025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>E</b> Last <b>Bomberger</b>		4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1902</b>
9. AGE (In years last birthday) <b>56</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Long</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. McNamee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Paul Kreglo</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Infarctions</b> (c) <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>2 weeks</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 13, 1956</b> , to <b>May 25, 1959</b> that I lost the deceased alive on <b>May 25, 1959</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <b>SIDNEY NOVENSTEIN</b>		ADDRESS (Street, city or town, state) <b>214 S. 1st St. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

6052

Washington

No.

City

Washington

Age

Sex

Marital

Profession

Place of Birth

Education

Occupation

Date of Death

Time of Death

Place of Death

Cause

Signature

Witness

Physician

Signature

Physician

Signature

*Johnston, Robert, test of death*  
*Johnston, Robert, test of death*  
*Johnston, Robert, test of death*

Signature

Signature

Signature

Signature

Signature

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06026

6028

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN It <b>6 MO.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X LEITERSBURG</b>		d. STREET ADDRESS <b>RT.# 5 HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WESTERN MD. CHRONIC DISEASE HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>May</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. R. MINER</b>		14. MOTHER'S MAIDEN NAME <b>IDA K. BAKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-05-2852</b>	
17. INFORMANT <b>MRS. JANE KAUFFMAN</b>		Address <b>RT.#5 HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion &amp; Edema</b> DUE TO <b>Generalized Carcinomatosis</b> DUE TO <b>Carcinoma of Left Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 mo.</b> <b>17 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-4</b> , <b>1959</b> , to <b>5-28</b> , <b>1959</b> , that I last saw the deceased alive on <b>5-28</b> , <b>1959</b> , and that death occurred at <b>7:10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>I. B. Lyon</b>		ADDRESS (Street, city or town, state) <b>1500 Pekany Ave. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>I. B. LYON, M.D.</b>		DATE SIGNED <b>5/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LEITERSBURG LUTH. CHURCH</b>	22d. LOCATION (City, town, or county) (State) <b>LEITERSBURG MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Z. Normant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

MEDICAL CERTIFICATION

2

1

091

I

CERTIFICATE OF DEATH

4038



CHURCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06027

6029

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>MORGAN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>DIANNA</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 14, 1947</u>
9. AGE (In years last birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11c. BIRTHPLACE (State or foreign country) <u>Hagerstown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EZRA G. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA H. SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>E. G. BROWN</u> Address <u>GT. CAPAPON, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory &amp; Circulatory failure</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain stem hemorrhage &amp; edema</u> DUE TO (c) <u>Brain tumor</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/11</u> , 1959, to <u>5/14</u> , 1959, that I last saw the deceased alive on <u>5/14</u> , 1959, and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>132 N. Potomac</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>A. F. Abdullah</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>A. F. Abdullah</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. NERO</u>	22d. LOCATION (City, town, or county) (State) <u>MORGAN CO. W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hunter</u> ADDRESS <u>Berkeley Springs, W. Va.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunter</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 CERTIFICATE OF DEATH  
 1922

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
 MIDDLE NAME: \_\_\_\_\_  
 SEX: ☐ MALE ☐ FEMALE  
 DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED  
 DATE OF DEATH: \_\_\_\_\_ PLACE OF DEATH: \_\_\_\_\_  
 CAUSE OF DEATH: \_\_\_\_\_  
 MEDICAL HISTORY: \_\_\_\_\_  
 SIGNATURE OF DECEASED: \_\_\_\_\_  
 SIGNATURE OF WITNESS: \_\_\_\_\_  
 SIGNATURE OF PHYSICIAN: \_\_\_\_\_  
 SIGNATURE OF CLERK: \_\_\_\_\_  
 OFFICIAL USE: \_\_\_\_\_  
 COUNTY OF DEATH: \_\_\_\_\_  
 CITY OF DEATH: \_\_\_\_\_  
 STATE OF DEATH: \_\_\_\_\_

RECEIVED BY: \_\_\_\_\_  
 DATE: \_\_\_\_\_  
 TIME: \_\_\_\_\_  
 OFFICE: \_\_\_\_\_  
 COUNTY: \_\_\_\_\_  
 STATE: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6087 CERTIFICATE OF DEATH

06028

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shepherdstown 85 x -3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>Box 353</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Susie</u> Middle <u>A.</u> Last <u>BURGAN</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>19</u> Year <u>1959</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct 21, 1875</u>
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington Co, Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph A. Davis</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lydia H. Wolford</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Mrs. Hazel Johnson</u>		<b>Address</b> <u>Baltimore Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis - Semilog</u> DUE TO (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>few min</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>none</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> to <u>May 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>59</u> , and that death occurred at <u>8 A.</u> M. from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>M E Byrkit</u>		<b>DATE SIGNED</b> <u>5-19-59</u>	
<b>PHYSICIAN'S NAME</b> (Type) <u>M. E. Byrkit</u>		<b>ADDRESS</b> (Street, city or town, state) <u>28 W Potomac st Williamsport Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>May 22-59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bakersville Cemetery</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Bakersville Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Albert Rex Williamsport, Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Arthur L. Kraus</u>	
<b>ADDRESS</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	

10000  
2004  
CERTIFICATE OF DEATH

1  
Name

Age

Sex

Color

Place of Birth

Signature

Date

## 6030 CERTIFICATE OF DEATH

06029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>69 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 West Side Ave.</b>				d. STREET ADDRESS <b>29 West Side Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank James Carpenter</b>				4. DATE OF DEATH Month Day Year <b>May 18 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 17, 1889</b>	
9. AGE (In years lost birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>County</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Henry Carpenter</b>				14. MOTHER'S MAIDEN NAME <b>Ella Eyler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
INFORMANT <b>Mrs. Vernie V. Carpenter Hag. Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INSUFFICIENCY</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>5-17-59</b> to <b>5-18-59</b> , that I lost sowing the deceased olive on <b>5-17-59</b> , and that death occurred at <b>7:34</b> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>135 N. Potomac St. Hagerstown Md.</b>			
ACTUAL SIGNATURE <b>D. J. Boyer</b> M.D.				DATE SIGNED <b>5-19-59</b>			
PHYSICIAN'S NAME (Type) <b>David J. Boyer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 20, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Funkstown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Funkstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

03030

0030 CENTRAL OF NEA

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22 West Side Ave.

22 West Side Ave.

May 15 1933

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135 N. Locust St.

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Washington

FOR STATE  
HEALTH DEPT.

6031

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr. Wells  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

06030

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, R#4</b>		c. LENGTH OF STAY IN TB <b>5 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairview Rd.</b>		e. STREET ADDRESS <b>Fairview Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Seth</b> Middle <b>Henry</b> Last <b>Charles</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1908</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Md. State Reformatory Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Charlton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Charles</b>		14. MOTHER'S MAIDEN NAME <b>Susan Carr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>214-09-5731</b>	
17. INFORMANT <b>Mrs. Margaret Lucile Charles</b>		Address <b>Hagerstown Md. R # 4</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Md. near Clear Spring Wash. Co</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 26 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of Deceased: [Illegible]

2. Sex: [Illegible]

3. Age: [Illegible]

4. Date of Birth: [Illegible]

5. Date of Death: [Illegible]

6. Place of Death: [Illegible]

7. Cause of Death: [Illegible]

8. Manner of Death: [Illegible]

9. Signature of Medical Examiner: [Illegible]

10. Date of Examination: [Illegible]

11. Signature of Coroner: [Illegible]

12. Date of Certification: [Illegible]

13. Signature of Registrar: [Illegible]

14. Date of Registration: [Illegible]

15. Signature of Health Officer: [Illegible]

16. Date of Filing: [Illegible]

17. Signature of [Illegible]: [Illegible]

18. Date of [Illegible]: [Illegible]

19. Signature of [Illegible]: [Illegible]

20. Date of [Illegible]: [Illegible]

21. Signature of [Illegible]: [Illegible]

22. Date of [Illegible]: [Illegible]

23. Signature of [Illegible]: [Illegible]

24. Date of [Illegible]: [Illegible]

25. Signature of [Illegible]: [Illegible]

26. Date of [Illegible]: [Illegible]

27. Signature of [Illegible]: [Illegible]

28. Date of [Illegible]: [Illegible]

29. Signature of [Illegible]: [Illegible]

30. Date of [Illegible]: [Illegible]

31. Signature of [Illegible]: [Illegible]

32. Date of [Illegible]: [Illegible]

33. Signature of [Illegible]: [Illegible]

34. Date of [Illegible]: [Illegible]

35. Signature of [Illegible]: [Illegible]

36. Date of [Illegible]: [Illegible]

37. Signature of [Illegible]: [Illegible]

38. Date of [Illegible]: [Illegible]

39. Signature of [Illegible]: [Illegible]

40. Date of [Illegible]: [Illegible]

41. Signature of [Illegible]: [Illegible]

42. Date of [Illegible]: [Illegible]

43. Signature of [Illegible]: [Illegible]

44. Date of [Illegible]: [Illegible]

45. Signature of [Illegible]: [Illegible]

46. Date of [Illegible]: [Illegible]

47. Signature of [Illegible]: [Illegible]

48. Date of [Illegible]: [Illegible]

49. Signature of [Illegible]: [Illegible]

50. Date of [Illegible]: [Illegible]

51. Signature of [Illegible]: [Illegible]

52. Date of [Illegible]: [Illegible]

53. Signature of [Illegible]: [Illegible]

54. Date of [Illegible]: [Illegible]

55. Signature of [Illegible]: [Illegible]

56. Date of [Illegible]: [Illegible]

57. Signature of [Illegible]: [Illegible]

58. Date of [Illegible]: [Illegible]

59. Signature of [Illegible]: [Illegible]

60. Date of [Illegible]: [Illegible]

61. Signature of [Illegible]: [Illegible]

62. Date of [Illegible]: [Illegible]

63. Signature of [Illegible]: [Illegible]

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82. Date of [Illegible]: [Illegible]

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86. Date of [Illegible]: [Illegible]

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89. Signature of [Illegible]: [Illegible]

90. Date of [Illegible]: [Illegible]

91. Signature of [Illegible]: [Illegible]

92. Date of [Illegible]: [Illegible]

93. Signature of [Illegible]: [Illegible]

94. Date of [Illegible]: [Illegible]

95. Signature of [Illegible]: [Illegible]

96. Date of [Illegible]: [Illegible]

97. Signature of [Illegible]: [Illegible]

98. Date of [Illegible]: [Illegible]

99. Signature of [Illegible]: [Illegible]

100. Date of [Illegible]: [Illegible]

RECEIVED  
JAN 15 1966  
BALTIMORE  
STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
1501 E. BALTIMORE AVENUE  
BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06031

## 6032 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>40 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARROLL GEORGE COOPER SR.</b>		4. DATE OF DEATH Month Day Year <b>MAY 10 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM COOPER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH HALLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-9129</b>	
17. INFORMANT <b>MRS. NELLIE K. COOPER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Prostate with metastasis</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recto-vesical Fistula</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 19 56</b> to <b>May 10, 19 59</b> , that I last saw the deceased alive on <b>May 9, 19 59</b> , and that death occurred at <b>6:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D. Clear Spring, Maryland 05/11/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Thorne</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thorne</b>	

10-431

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

1930

Reg. No. 10

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White	
DATE OF DEATH May 12, 1930		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		MEDICAL HISTORY Hypertension	
DATE OF BIRTH April 15, 1885		PLACE OF BIRTH Maryland		CITY Baltimore		COUNTY Baltimore	
MANNER OF BIRTH Normal		CAUSE OF BIRTH Normal		DISEASE OR INJURY None		MEDICAL HISTORY None	
DATE OF DEATH May 12, 1930		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		MEDICAL HISTORY Hypertension	
DATE OF BIRTH April 15, 1885		PLACE OF BIRTH Maryland		CITY Baltimore		COUNTY Baltimore	
MANNER OF BIRTH Normal		CAUSE OF BIRTH Normal		DISEASE OR INJURY None		MEDICAL HISTORY None	

1

1. Name of deceased: JAMES H. HARRIS  
2. Age: 45  
3. Sex: Male  
4. Race: White  
5. Date of death: May 12, 1930  
6. Place of death: Home  
7. City: Baltimore  
8. County: Baltimore  
9. Manner of death: Natural  
10. Cause of death: Heart Disease  
11. Disease or injury: Coronary Artery Disease  
12. Medical history: Hypertension  
13. Date of birth: April 15, 1885  
14. Place of birth: Maryland  
15. City: Baltimore  
16. County: Baltimore  
17. Manner of birth: Normal  
18. Cause of birth: Normal  
19. Disease or injury: None  
20. Medical history: None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06032

6033

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>545 Maryland Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>545 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WESLEY</b> Last <b>CRAWFORD</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1883</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Berkeley Co. W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaiah Crawford</b>		14. MOTHER'S MAIDEN NAME <b>Sally Mowdey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. J. W. Crawford</b>		Address <b>545 Maryland Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>General Arteriosclerosis</b> (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-1</b> , 19 <b>58</b> , to <b>5-15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-14-59</b> , 19 <b>59</b> , and that death occurred at <b>2:45 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. W. Crawford</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>	
DATE SIGNED <b>5/16/59</b>			
PHYSICIAN'S NAME (Type) <b>DREW DITTO</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thoma</b>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH & COUNTY		2. SEX Male Female		3. RACE White Negro	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. NAME OF DECEASED		8. AGE		9. SEX	
10. RACE		11. OCCUPATION		12. CAUSE OF DEATH	
13. DISEASE		14. SYMPTOMS		15. MEDICAL HISTORY	
16. PREVIOUS ILLNESS		17. PREVIOUS SURGERY		18. PREVIOUS TRAUMA	
19. PREVIOUS DRUGS		20. PREVIOUS ALCOHOL		21. PREVIOUS TOBACCO	
22. PREVIOUS OTHER		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
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1

1. NAME OF DECEASED  
2. SEX  
3. RACE  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF DEATH  
7. NAME OF DECEASED  
8. AGE  
9. SEX  
10. RACE  
11. OCCUPATION  
12. CAUSE OF DEATH  
13. DISEASE  
14. SYMPTOMS  
15. MEDICAL HISTORY  
16. PREVIOUS ILLNESS  
17. PREVIOUS SURGERY  
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102. PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6034

## CERTIFICATE OF DEATH

Reg. Dist. No.

06033

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa.</u>		75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Conv. Hospital</u>		d. STREET ADDRESS <u>24 N. Carlisle St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>PEARL</u> Last <u>CRIDER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>B. F. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William G. Hoffman</u>		Address <u>RD 2 Mercersburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> DUE TO <u>Carcinoma Uterus c</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Metastases to Lungs</u> DUE TO <u>Metastases to Lungs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-13-59</u> , to <u>5-22-59</u> , that I last saw the deceased alive on <u>5-22-59</u> and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. E. W. Dittus</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>5/23/59</u>	
PHYSICIAN'S NAME (Type) <u>ATT E W DITTUS</u>		<u>Hagerstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Franklin Co., Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Wynnich</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



6035

## CERTIFICATE OF DEATH

06034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		c. LENGTH OF STAY IN 1b <b>22 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown, Maryland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>449 N Jonathan Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elenora</b> Middle <b>Elizabeth</b> Last <b>Gross</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17 1905</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>John Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Susan Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mrs. Anna Gross 449 N Jonathan St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>9 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept.</b> , 19 <b>50</b> , to <b>July 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 1959</b> , 19 <b>59</b> , and that death occurred at <b>5</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Philip J. Hirshman</b> M.D. <b>159 W. Washington St., Hagerstown, Md. 5/15/59</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-18-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md.</b>				ADDRESS <b>449 N Jonathan St.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10034

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Tennessee	
10. OCCUPATION Member of Congress		11. EDUCATION High School Graduate		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. COLOR White		15. HEIGHT 5' 11"	
16. WEIGHT 175 lbs		17. HAIR Brown		18. EYES Blue	
19. BLOOD TYPE O+		20. SIGNATURE OF DECEASED (Signature)		21. SIGNATURE OF WITNESS (Signature)	
22. SIGNATURE OF PHYSICIAN (Signature)		23. SIGNATURE OF CORONER (Signature)		24. SIGNATURE OF JURY (Signature)	
25. SIGNATURE OF DISTRICT ATTORNEY (Signature)		26. SIGNATURE OF STATE'S ATTORNEY (Signature)		27. SIGNATURE OF DEFENSE ATTORNEY (Signature)	
28. SIGNATURE OF JUDGE (Signature)		29. SIGNATURE OF CLERK (Signature)		30. SIGNATURE OF NOTARY (Signature)	

1

TO BE FILLED IN BY THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA  
IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the said Court, at Washington, D.C., this 10th day of April, 1968.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.


# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6088 CERTIFICATE OF DEATH

06035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>		c. LENGTH OF STAY IN 1b <u>34 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. R.I.</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>R.</u> Last <u>CROSS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1959</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-19-1887</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MOLESVILLE FRED. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD. U.S.A.</u>	
13. FATHER'S NAME <u>HENRY LEE WOLF</u>			14. MOTHER'S MAIDEN NAME <u>IDA KLINE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>D.W. CROSS</u> Address <u>HAGERSTOWN MD. Route 1-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12hrs.</u>  <u>3 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5-25-59</u> , 19____, to <u>5-26-59</u> , 19____, that I last saw the deceased alive on <u>5-25-59</u> , 19____, and that death occurred at <u>7:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u> <u>5-27-59</u> PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Best</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE REGISTRAR, THIS CERTIFICATE SHOULD BE DELIVERED TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6089 CERTIFICATE OF DEATH

Reg. Dist. No. 06036

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>90 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		d. STREET ADDRESS <b>129 E. Potomac St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>129 E. Potomac Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Kreigh</b> Last <b>Cushwa</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14 1869</b>
9. AGE (In years last birthday) <b>90</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>6</b>	
11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>6</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner Coal &amp; Brick</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal &amp; Brick Yards</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Victor Cushwa</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Kreigh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 18 8779</b>	
17. INFORMANT <b>David Kreigh Cushwa Jr.</b>		Address <b>131 E. Potomac Williamsport Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Carcinoma of urinary bladder</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Emphysema of lungs.</b> (b) <b>Emphysema of lungs.</b> (c) <b>Hemiplegia from stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>3 yrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia from stroke</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov</b> , 1956, to <b>May 21</b> , 1959, that I lost s/he the deceased alive on <b>May 20</b> , 1959, and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph C. Crisp M.D.</b>		ADDRESS (Street, city or town, state) <b>115 King St. Hagerstown Md.</b>	
DATE SIGNED <b>JOSEPH C. CRISP M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leal Williamsport Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

10438

2002 CREDIT CARD

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10438

10438

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6036 CERTIFICATE OF DEATH

06037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Fulton</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Jane</b> Last <b>Doneen</b>				4. DATE OF DEATH Month <b>5</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10. 1879</b>		9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Bishop</b>				14. MOTHER'S MAIDEN NAME <b>Anna Bele Moss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Jessie Mitchell Brosius W.VA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema, generalized anasarca</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>unknown</b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriolamephrosclerosis and uremia, duration unknown</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1959</b> , to <b>May 3, 1959</b> , that I last saw the deceased alive on <b>May 3, 1959</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg. 5/5/59</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William T. Layman</b> M.D.				DATE SIGNED <b>5/5/59</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>				Hagerstown Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5.7.59</b>		22c. NAME OF CEMETERY OR <b>Buck Valley Christian</b>		22d. LOCATION (City, town, or county) (State) <b>Buck Valley Fulton Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Shaw Hancock mal</b>				24a. REC'D BY REGISTRAR <b>MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06038

## 6037 CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROHRERSVILLE</u>		d. STREET ADDRESS <u>1 MAIN ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>081 WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>DELLA K. FABLE</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MAY - 20 - 19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 2 - 1884</u>	
9. AGE (In years, last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MIDDLETOWN FRED. CO. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ISAAC LONG</u>			
14. MOTHER'S MAIDEN NAME <u>ETTA YOUNGINS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MRS. GEORGE BEAR ROHRERSVILLE MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Branchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Undernutrition, Arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 May, 1959</u> , to <u>20 May, 1959</u> , that I last saw the deceased alive on <u>19 May, 1959</u> , and that death occurred at <u>9:05 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard T. Binford</u>				DATE SIGNED <u>5/21/59</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 22, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROHRERSVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ROHRERSVILLE WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Best</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
CERTIFICATE OF DEATH

1907

3

NOT FOR SALE

1

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

TO BE FILLED BY THE REGISTRAR OF DEATHS  
IN THE DISTRICT OF COLUMBIA  
AND IN THE DISTRICT OF COLUMBIA  
AND IN THE DISTRICT OF COLUMBIA

<div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>Item 18 Film 242 5-21-59,ams</div> <div>6038</div> <div>Item 11, Film 242, 5-11-59, mnd</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</div> <div>06039</div> </div>									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH o. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>931 F Lanvale Street</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>931 F Lanvale Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>SHANK</b> Last <b>ELKINS</b>					4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 11, 1911</b>		9. AGE (In years last birthday) <b>47</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Shawsville, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Ralph David Shank</b>					14. MOTHER'S MAIDEN NAME <b>Hazel Jewel</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>undetermined</b>		17. INFORMANT <b>Madeline Belt- Box 455- Hagerstown, Maryland</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined - pending autopsy report</b> 581.0 DUE TO <b>Acute &amp; Chronic Pyelonephritis with renal necrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Cirrhosis of liver</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <b>S. Robert Wells</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Piedmont Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Shawsville, Montgomery Co Va</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew H. Coffman</b> ADDRESS <b>Hagerstown, Md.</b>					24a. REC'D BY REGISTRAR <b>MAY 12 1959</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
0038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		May 15, 1968		Home	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Heart Disease		Natural		Teacher		High School		Catholic		Married	
History of Illness		Previous Illnesses		Family History		Social History		Habitual Habits		Other Remarks	
Chest Pain		Hypertension		None		Nonsmoker		Alcohol		None	
Treatment		Autopsy		Burial		Disposition of Body		Signature of Examiner		Signature of Coroner	
Medicine		No		Yes		Cremation		[Signature]		[Signature]	
Remarks		Disposition of Records		Disposition of Body		Disposition of Organs		Disposition of Tissues		Disposition of Bones	
None		Yes		Yes		Yes		Yes		Yes	
Disposition of Records		Disposition of Body		Disposition of Organs		Disposition of Tissues		Disposition of Bones		Disposition of Other	
Yes		Yes		Yes		Yes		Yes		Yes	
Disposition of Other		Disposition of Other		Disposition of Other		Disposition of Other		Disposition of Other		Disposition of Other	
Yes		Yes		Yes		Yes		Yes		Yes	
Disposition of Other		Disposition of Other		Disposition of Other		Disposition of Other		Disposition of Other		Disposition of Other	
Yes		Yes		Yes		Yes		Yes		Yes	

8.5.68

MAY 15 1968

TO DEPUTY MEDICAL EXAMINER: This certificate should be pending 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## 6039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>17 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>315 N. Cleveland Ave.</b>				d. STREET ADDRESS <b>315 N. Cleveland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MERNIE</b> Middle <b>SNOWDEN</b> Last <b>EVANS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1904</b>		9. AGE (In years last birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mineral County, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Isaac Evans</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Delila Hipp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>087-10-3653</b>		17. INFORMANT Address <b>Jean Mazzulla 602 Summit Ave. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>322.0</b> DUE TO <b>Auto Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auto Alcoholism</b> DUE TO (c) <b>Auto Alcoholism</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>J. E. W. Dittus</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b> <b>Wm. A. Hunt</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

1. NAME OF DECEASED: [REDACTED]  
 2. DATE OF DEATH: [REDACTED]  
 3. PLACE OF DEATH: [REDACTED]  
 4. SEX: [REDACTED] AGE: [REDACTED]  
 5. OCCUPATION: [REDACTED]  
 6. MARITAL STATUS: [REDACTED]  
 7. CAUSE OF DEATH: [REDACTED]  
 8. MANNER OF DEATH: [REDACTED]  
 9. SIGNATURE OF EXAMINER: [REDACTED]  
 10. DATE OF EXAMINATION: [REDACTED]

11. NAME OF HUSBAND: [REDACTED]  
 12. NAME OF WIFE: [REDACTED]  
 13. NAME OF CHILDREN: [REDACTED]  
 14. NAME OF SISTER: [REDACTED]  
 15. NAME OF BROTHER: [REDACTED]

16. NAME OF NEAREST RELATIVE: [REDACTED]  
 17. ADDRESS OF NEAREST RELATIVE: [REDACTED]  
 18. NAME OF NEXT OF KIN: [REDACTED]  
 19. ADDRESS OF NEXT OF KIN: [REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
item 2 FilmG242 5-18-59 et  
6090 CERTIFICATE OF DEATH

06041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>30 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEPER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLEMMIE VIRGINIA FORD</u>				4. DATE OF DEATH Month Day Year <u>MAY - 8 - 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY - 26 - 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. Co. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JAMES P. FORD</u>			
14. MOTHER'S MAIDEN NAME <u>MALINDA C. YOUNG</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>HUGH A. FORD</u> Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>34 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>April 19, 1956</u> , to <u>May 8, 1959</u> , that I last saw the deceased alive on <u>May 7, 1959</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				DATE SIGNED <u>5/8/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bost</u> ADDRESS <u>Boonsboro MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
CERTIFICATE OF DEATH

WILLIAM EDWARD

WILLIAM EDWARD

Name of Deceased		Date of Death	
Age		Sex	
Race		Color	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Occupation		Education	
Marital Status		Religion	
Date of Marriage		Date of Divorce	
Date of Death		Time of Death	
Place of Death		Hospital or Institution	
Physician		Medical Examiner	
Funeral Home		Burial Place	
Date of Burial		Time of Burial	
Signature of Registrar		Signature of Medical Examiner	
Signature of Funeral Home		Signature of Burial Place	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CLEAR SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VICTOR</b> Middle <b>G.</b> Last <b>FUNKHOUSER</b>		4. DATE OF DEATH Month <b>5</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LUMBERMAN</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE</b>	
11c. BIRTHPLACE (State or foreign country) <b>INDIAN SPRINGS, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>VICTOR FUNKHOUSER</b>		14. MOTHER'S MAIDEN NAME <b>MARY STEELE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-28-9556</b>	
17. INFORMANT <b>MRS. ZORA FUNKHOUSER</b>		Address <b>CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO <b>Gunshot Wound of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 minutes</b> DUE TO (c) <b>10 minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gunshot</b>	
20c. TIME OF INJURY Hour <b>4:42</b> a.m. <b>6-17</b> p.m. <b>1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Clear Spring Washington Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>DREW DITTE Jr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>DREW DITTE Jr</b>		DATE SIGNED <b>5/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b>		ADDRESS <b>CLEAR SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		TOXICOLOGY		AUTOPSY		LABORATORY		HISTOLOGY		PATHOLOGY	
FINDINGS		DISCUSSION		CONCLUSIONS		REMARKS		SIGNATURE		DATE	

15121000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6091 CERTIFICATE OF DEATH

06043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>WASH.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BIG POOL</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GEHR. ROAD</b>				d. STREET ADDRESS <b>GEHR ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>RACHAEL ANN GEHR</b>				4. DATE OF DEATH Month Day Year <b>5 13 1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 20, 1880</b>		9. AGE (In years last birthday) <b>78</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>SHANKTOWN, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JACOB SHANK</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA DAVIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>R. RAYMOND GEHR</b> Address <b>BIG POOL, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Hypertensive Sclerosis</b> DUE TO (c) <b>2 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1959</b> , to <b>May 13, 1959</b> , that I last saw the deceased alive on <b>May 11, 1959</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.				ADDRESS (Street, city or town, state) <b>Clear Spring Md</b> DATE SIGNED <b>5/13/59</b>			
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/16/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SHANKTOWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BIG POOL MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b>				ADDRESS <b>CLEAR SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Race _____		Birth Date _____	
Place of Birth _____		Usual Residence _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6092

## CERTIFICATE OF DEATH

Reg. Dist. No.

06044

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Keyser, W. Va.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hancock Nursing Home</b>		d. STREET ADDRESS <b>Route 3, Keyser, W. Va.</b>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Wm.</b> Last <b>Goodyear</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1890</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>01</b> Days <b>X</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tinsmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Goodyear</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Huff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-12-216</b>	
17. INFORMANT <b>Mrs. E. Louis Fisher, Cumberland, Md.</b>		Address <b>27 Utah Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic myocarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/15</b> , 19 <b>59</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. E. Tabler, M.D.</b>		ADDRESS (Street, city or town, state) <b>Hancock, Md.</b>	
PHYSICIAN'S NAME (Type) <b>H. E. Tabler M.D.</b>		DATE SIGNED <b>5/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>		24a. REC'D BY REGISTRAR <b>MAY 19 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haas</b>			

CERTIFICATE OF DEATH

1. Name of Deceased: JOHN J. SMITH

2. Sex: Male

3. Age: 45

4. Date of Birth: 1910

5. Date of Death: 1955

6. Place of Death: Home

7. Cause of Death: Heart Disease

8. Signature of Physician: [Signature]

9. Signature of Registrar: [Signature]

10. Date of Registration: 1955

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06045

6093 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>BROWNSVILLE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA</u> <u>MAY</u> <u>HAHN</u>				4. DATE OF DEATH Month Day Year <u>MAY-28</u> <u>19</u> <u>59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-26-1872</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>4</u> <u>2</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>YARROWSBURG WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID FOUCHE</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA NORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MERREL HAHN BROWNSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter-arteriole Heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>59</u> , to <u>May 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Brownsville</u>		DATE SIGNED <u>5/29/59</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Hahn</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY-30-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BROWNSVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE WASH. CO. MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Bart</u>				ADDRESS <u>Brownsboro MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hahn</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Form No. 10

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Name of funeral home		14. Name of undertaker		15. Name of cemetery		16. Name of church	
17. Name of family		18. Name of next of kin		19. Name of executor		20. Name of administrator	
21. Name of guardian		22. Name of trustee		23. Name of agent		24. Name of attorney	
25. Name of executor		26. Name of administrator		27. Name of guardian		28. Name of trustee	
29. Name of agent		30. Name of attorney		31. Name of executor		32. Name of administrator	
33. Name of guardian		34. Name of trustee		35. Name of agent		36. Name of attorney	
37. Name of executor		38. Name of administrator		39. Name of guardian		40. Name of trustee	
41. Name of agent		42. Name of attorney		43. Name of executor		44. Name of administrator	
45. Name of guardian		46. Name of trustee		47. Name of agent		48. Name of attorney	
49. Name of executor		50. Name of administrator		51. Name of guardian		52. Name of trustee	
53. Name of agent		54. Name of attorney		55. Name of executor		56. Name of administrator	
57. Name of guardian		58. Name of trustee		59. Name of agent		60. Name of attorney	
61. Name of executor		62. Name of administrator		63. Name of guardian		64. Name of trustee	
65. Name of agent		66. Name of attorney		67. Name of executor		68. Name of administrator	
69. Name of guardian		70. Name of trustee		71. Name of agent		72. Name of attorney	
73. Name of executor		74. Name of administrator		75. Name of guardian		76. Name of trustee	
77. Name of agent		78. Name of attorney		79. Name of executor		80. Name of administrator	
81. Name of guardian		82. Name of trustee		83. Name of agent		84. Name of attorney	
85. Name of executor		86. Name of administrator		87. Name of guardian		88. Name of trustee	
89. Name of agent		90. Name of attorney		91. Name of executor		92. Name of administrator	
93. Name of guardian		94. Name of trustee		95. Name of agent		96. Name of attorney	
97. Name of executor		98. Name of administrator		99. Name of guardian		100. Name of trustee	

## 6094 CERTIFICATE OF DEATH

06046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b> 10 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hawn Convelescent Home</b>		d. STREET ADDRESS <b>W. Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Fleet</b> Last <b>Harbaugh</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegrapher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West. Md. RR</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Walter S. Harbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Harbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>	
INFORMANT <b>Mrs. Ray Nogle</b>		Address <b>Thurmont, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized,</b> DUE TO <b>Old age.</b> (c) <b>Old age.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>10 years</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 29, 1954</b> , to <b>May 8, 1959</b> that I last saw the deceased alive on <b>May 7, 1959</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Thayer</b>		ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa 8 May 59</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE SECRETARY OF THE ARMY

Washington

Maryland

Highland

Thomson

W. Main Street

Howe Corporation

William H. Hest

William H. Hest

Male White

Oct. 11, 1900

Test. No. 11

Maryland

Valter S. Harbough

Baron J. Harbough

Mrs. Ray Noble

Thomson, Maryland

No

Oct 11 - 1900

Regiment 1, Cavalry

Thomson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

60935

## CERTIFICATE OF DEATH

Reg. Dist. No.

06047

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAPLAND RURAL</u>		c. LENGTH OF STAY IN 1b <u>26 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GAPLAND - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GAPLAND MD.</u>				d. STREET ADDRESS <u>GAPLAND MD.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>THOMAS STANLEY HAYNES</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MAY-20 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-1-1894</u>		9. AGE (In years lost birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>POHRENSVILLE WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. C. HAYNES</u>				14. MOTHER'S MAIDEN NAME <u>CLARA POEFFENBERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>215-26-7846</u>		17. INFORMANT Address <u>MRS. MABEL HAYNES GAPLAND MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20, 1959</u> , to <u>May 20, 1959</u> , that I last saw the deceased alive on <u>May 20, 1959</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Boonsboro, Md.</u> DATE SIGNED <u>5/21/59</u> ACTUAL SIGNATURE <u>G. W. Williams</u> M.D. PHYSICIAN'S NAME (Type) <u>G. W. Williams</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLESANT VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BURKETTSTVILLE TOWN, GA. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Best</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

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## 6041 CERTIFICATE OF DEATH

Reg. Dist. No.

06048

1. PLACE OF DEATH o. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Pd.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Interstown</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGIA ANN Helfrick</u>		4. DATE OF DEATH Month Day Year <u>May 20 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/59</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Helfrick</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Brezler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis of Newborn</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity &amp; prematurity (due 8/10/59)</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/20</u> , 19 <u>59</u> , to <u>5/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Young</u>		M.D. <u>101 King Street</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>		<u>Interstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/23/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Martin Roe</u>		ADDRESS <u>Waynesboro, Penna.</u>	
24a. REC'D BY REGISTRAR <u>MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081286 x vi



## 6042 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Home</u>				e. STREET ADDRESS <u>310 So Cannon Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>FRANKLIN</u> Last <u>HENSON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Hagerstown Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Henson</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-040312</u>		17. INFORMANT Address <u>M. Louise Gimple 121 E. Antietam St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug. 16, 1958</u> , to <u>May 3, 1959</u> , that I last saw the deceased alive on <u>May 1, 1959</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. A. Bell</u>				ADDRESS (Street, city or town, state) <u>119 North Potomac St., May 4, 1959</u>			
PHYSICIAN'S NAME (Type) <u>R. A. Bell, M.D.</u>				M.D. <u>Hagerstown, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6043 CERTIFICATE OF DEATH

Reg. Dist. No. 303

06050

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>9 Wks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Memorial Home</b>				d. STREET ADDRESS <b>310 So Cannon Ave</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>NANCY BELLE HENSON</b>				4. DATE OF DEATH Month Day Year <b>May 4 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1 1874</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Rutherford</b>				14. MOTHER'S MAIDEN NAME <b>Frances Riley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>M. Louise Gimple 121 E. Antietam St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinome primary in Colon.</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11, 1957</b> to <b>May 4, 1959</b> , that I last saw the deceased alive on <b>May 4, 1959</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. A. Bell</b>				ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b>			
DATE SIGNED <b>May 4, 1959.</b>							
PHYSICIAN'S NAME (Type) <b>R. A. Bell, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>			

2003 CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, First, Middle Initial) JAMES EARL RAY		2. SEX Male	
3. AGE (Years, Months, Days) 39		4. DATE OF BIRTH 12/5/23	
5. PLACE OF BIRTH Memphis, Tennessee		6. RACE White	
7. OCCUPATION Singer, Songwriter		8. MARITAL STATUS Single	
9. US BIRTHPLACE Tennessee		10. US CITIZENSHIP Naturalized	
11. SOCIAL SECURITY NUMBER [REDACTED]		12. MOTHER'S MAIDEN NAME [REDACTED]	
13. DATE OF DEATH 4/4/68		14. TIME OF DEATH 11:57 AM	
15. PLACE OF DEATH Prison, Nashville, Tennessee		16. CAUSE OF DEATH Heart Disease	
17. MANNER OF DEATH Natural		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF PHYSICIAN [Signature]	
21. SIGNATURE OF CORONER [Signature]		22. SIGNATURE OF REGISTRAR [Signature]	
23. SIGNATURE OF CLERK [Signature]		24. SIGNATURE OF JUDGE [Signature]	
25. SIGNATURE OF SHERIFF [Signature]		26. SIGNATURE OF DISTRICT ATTORNEY [Signature]	
27. SIGNATURE OF COUNTY CLERK [Signature]		28. SIGNATURE OF CITY CLERK [Signature]	
29. SIGNATURE OF TOWNSHIP CLERK [Signature]		30. SIGNATURE OF VILLAGE CLERK [Signature]	
31. SIGNATURE OF POST OFFICE CLERK [Signature]		32. SIGNATURE OF SCHOOL CLERK [Signature]	
33. SIGNATURE OF CHURCH CLERK [Signature]		34. SIGNATURE OF SYNAGOGUE CLERK [Signature]	
35. SIGNATURE OF MOSQUE CLERK [Signature]		36. SIGNATURE OF TEMPLE CLERK [Signature]	
37. SIGNATURE OF OTHER CLERK [Signature]		38. SIGNATURE OF OTHER CLERK [Signature]	
39. SIGNATURE OF OTHER CLERK [Signature]		40. SIGNATURE OF OTHER CLERK [Signature]	
41. SIGNATURE OF OTHER CLERK [Signature]		42. SIGNATURE OF OTHER CLERK [Signature]	
43. SIGNATURE OF OTHER CLERK [Signature]		44. SIGNATURE OF OTHER CLERK [Signature]	
45. SIGNATURE OF OTHER CLERK [Signature]		46. SIGNATURE OF OTHER CLERK [Signature]	
47. SIGNATURE OF OTHER CLERK [Signature]		48. SIGNATURE OF OTHER CLERK [Signature]	
49. SIGNATURE OF OTHER CLERK [Signature]		50. SIGNATURE OF OTHER CLERK [Signature]	
51. SIGNATURE OF OTHER CLERK [Signature]		52. SIGNATURE OF OTHER CLERK [Signature]	
53. SIGNATURE OF OTHER CLERK [Signature]		54. SIGNATURE OF OTHER CLERK [Signature]	
55. SIGNATURE OF OTHER CLERK [Signature]		56. SIGNATURE OF OTHER CLERK [Signature]	
57. SIGNATURE OF OTHER CLERK [Signature]		58. SIGNATURE OF OTHER CLERK [Signature]	
59. SIGNATURE OF OTHER CLERK [Signature]		60. SIGNATURE OF OTHER CLERK [Signature]	
61. SIGNATURE OF OTHER CLERK [Signature]		62. SIGNATURE OF OTHER CLERK [Signature]	
63. SIGNATURE OF OTHER CLERK [Signature]		64. SIGNATURE OF OTHER CLERK [Signature]	
65. SIGNATURE OF OTHER CLERK [Signature]		66. SIGNATURE OF OTHER CLERK [Signature]	
67. SIGNATURE OF OTHER CLERK [Signature]		68. SIGNATURE OF OTHER CLERK [Signature]	
69. SIGNATURE OF OTHER CLERK [Signature]		70. SIGNATURE OF OTHER CLERK [Signature]	
71. SIGNATURE OF OTHER CLERK [Signature]		72. SIGNATURE OF OTHER CLERK [Signature]	
73. SIGNATURE OF OTHER CLERK [Signature]		74. SIGNATURE OF OTHER CLERK [Signature]	
75. SIGNATURE OF OTHER CLERK [Signature]		76. SIGNATURE OF OTHER CLERK [Signature]	
77. SIGNATURE OF OTHER CLERK [Signature]		78. SIGNATURE OF OTHER CLERK [Signature]	
79. SIGNATURE OF OTHER CLERK [Signature]		80. SIGNATURE OF OTHER CLERK [Signature]	
81. SIGNATURE OF OTHER CLERK [Signature]		82. SIGNATURE OF OTHER CLERK [Signature]	
83. SIGNATURE OF OTHER CLERK [Signature]		84. SIGNATURE OF OTHER CLERK [Signature]	
85. SIGNATURE OF OTHER CLERK [Signature]		86. SIGNATURE OF OTHER CLERK [Signature]	
87. SIGNATURE OF OTHER CLERK [Signature]		88. SIGNATURE OF OTHER CLERK [Signature]	
89. SIGNATURE OF OTHER CLERK [Signature]		90. SIGNATURE OF OTHER CLERK [Signature]	
91. SIGNATURE OF OTHER CLERK [Signature]		92. SIGNATURE OF OTHER CLERK [Signature]	
93. SIGNATURE OF OTHER CLERK [Signature]		94. SIGNATURE OF OTHER CLERK [Signature]	
95. SIGNATURE OF OTHER CLERK [Signature]		96. SIGNATURE OF OTHER CLERK [Signature]	
97. SIGNATURE OF OTHER CLERK [Signature]		98. SIGNATURE OF OTHER CLERK [Signature]	
99. SIGNATURE OF OTHER CLERK [Signature]		100. SIGNATURE OF OTHER CLERK [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06051

6044

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOONSBORO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>081 WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>POTOMAC ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARVIN EUGENE HEIR</u>				4. DATE OF DEATH Month Day Year <u>MAY - 13 - 19 59</u>			
5. SEX <u>MALF</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY - 6 - 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FAIRCHILD AIRCRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. CO. MD. U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>	
13. FATHER'S NAME <u>HURLEY C. HEIR</u>				14. MOTHER'S MAIDEN NAME <u>VEDA THOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-01-8271</u>		17. INFORMANT Address <u>MRS. VEDA HEIR BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Signed Colon</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatic Heart Disease with mitral Valvulitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-22-56</u> , 19 <u>56</u> , to <u>5-13-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>59</u> , and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dalton M. Welty</u> M.D. <u>Hagerstown, Maryland</u>				ADDRESS (Street, city or town, state) <u>Boonsboro Wash. Co. Md.</u> DATE SIGNED <u>5-15-59</u>			
PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-16-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Best</u> <u>Boonsboro MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



6096

CERTIFICATE OF DEATH

Reg. Dist. No.

06052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>WASH.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL CLEAR SPRING</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROCKDALE ROAD</b>				d. STREET ADDRESS <b>ROCKDALE ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>HIGGINS</b> Last <b>SR.</b>				4. DATE OF DEATH Month <b>5</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 3, 1883</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN LUTHER HIGGINS</b>				14. MOTHER'S MAIDEN NAME <b>MARY JANE CLOPPER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>FREDERICK W. HIGGINS HAGERSTOWN RT4 MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Sclerosis</b> DUE TO (c) <b>Chr. Endocarditis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Feb. 19 54</b> to <b>May 4, 19 59</b> , that I last saw the deceased alive on <b>April 15, 19 59</b> , and that death occurred at <b>8:00</b> M from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David R. Brewer</b>		M.D. <b>Clear Spring Md.</b>		DATE SIGNED <b>5/6/59</b>			
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/7/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BLAIRS VALLEY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b> ADDRESS <b>CLEAR SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6097 CERTIFICATE OF DEATH

Reg. Dist. No.

06053

1. PLACE OF DEATH a. COUNTY <del>Frederick</del> Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport-Rural		c. LENGTH OF STAY IN 1b Since 3/1958		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		10/11-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS 221 South Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LENA GECELIA HILDEBRAND				4. DATE OF DEATH Month Day Year May 25, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb 1872	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis M. Hildebrand				14. MOTHER'S MAIDEN NAME Laura Victoria Staley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unk		17. INFORMANT Address Lewis H. Knock, 1016-A N. Market St., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular System DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10, 1959, to 5-25, 1959, that I last saw the deceased alive on 5-20-59, 19, and that death occurred at P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5/23/59							
ACTUAL SIGNATURE Dr. E.W. Dittus		M.D.		H. E. Gustafson Md		5/23/59	
PHYSICIAN'S NAME (Type) DR E.W. DITTUS JR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Charles S. Hume	



CERTIFICATE OF DEATH

Reg. Dist. No.

6045

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		d. STREET ADDRESS <b>Harpers Ferry Road</b>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>TILGHMAN</b> Last <b>HOUSER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1882</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Samples Manor, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Tilghman Houser</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jane Haines</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-09-7659</b>	
INFORMANT <b>Mr. Jesse H. Houser</b> <b>RFD#1, Harpers Ferry, West Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA RIGHT LOWER LOBE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ABDOMINAL CARCINOMATOSIS</b> DUE TO (c) <b>CARCINOMA RIGHT KIDNEY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>6 MONTHS</b> <b>1 YEAR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LEFT INGUINAL HERNIA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>APRIL 22, 1959</b> to <b>MAY 22, 1959</b> that I last saw the deceased alive on <b>MAY 22, 1959</b> and that death occurred at <b>7:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1500 PENNSYLVANIA AVE</b> DATE SIGNED <b>5/22/59</b>			
ACTUAL SIGNATURE <b>George Bercu</b> M.D.		PHYSICIAN'S NAME (Type) <b>DR. GEORGE BERCU</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Samples Manor, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Knaus</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>			

CERTIFICATE OF DEATH

Washington, D.C.  
In accordance with the laws of the District of Columbia, the undersigned, a duly qualified physician, do hereby certify that  
Name of Deceased: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Date of Birth: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Cause of Death: [illegible]  
Manner of Death: [illegible]  
Signature of Physician: [illegible]  
Signature of Medical Examiner: [illegible]  
Signature of Coroner: [illegible]  
Signature of Registrar: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6046 CERTIFICATE OF DEATH

06055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLIVE</b> Middle <b>O.</b> Last <b>HUFF</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>x</b> Hours <b>-</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lovettsville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James D. Ponton</b>		14. MOTHER'S MAIDEN NAME <b>Emma Mason</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Pauline Bell, Hagerstown, Md. R.D. # 5</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>OBSTRUCTION OF RT. KIDNEY</b> DUE TO (c) <b>ADENOCARCINOMA OF UTERUS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>3-4 mo</b> <b>6 mo</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1958</b> to <b>25 MAY 1959</b> , that I last saw the deceased alive on <b>25 MAY 1959</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Paul H. Webster</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leitersburg, Wash. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Marlin Roe</b>		24a. REC'D BY REGISTRAR <b>MAY 27 59</b>	
ADDRESS <b>Waynesboro, Penna.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Name of deceased		John A. Johnson	
Sex		Male	
Age		45	
Date of birth		May 20, 1897	
Place of birth		Baltimore, Md.	
Cause of death		Heart - disease	
Date of death		May 20, 1942	
Place of death		Baltimore, Md.	
Physician		Dr. John A. Johnson	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Date of registration		May 20, 1942	
Place of registration		Baltimore, Md.	

## 6047 CERTIFICATE OF DEATH

06056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8 1959</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>Hagerstown, Md</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Wayne Cunningham</b>		<b>Geraldine Johnson</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<b>Wayne Cunningham</b>		<b>Geraldine Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<b>101 Address Blooms Alley</b>	
		<b>Mrs. Ethel Johnson Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x Premature Birth 5 1/2 hrs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>20 minutes</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8, 1959</b> , to <b>May 8, 1959</b> , that I last saw the deceased alive on <b>May 8, 1959</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D.		<b>159 W. Washington St. Hagerstown, Md. 5/9/59</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>5-11-1959</b>	<b>Rose Hill Cemetery</b>	<b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Harrison</i>		2. SEX <i>Male</i>		3. AGE <i>68</i>	
4. DATE OF DEATH <i>Jan 15 1944</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESS <i>John A. Harrison</i>		12. SIGNATURE OF DECEASED <i>John A. Harrison</i>	
13. SIGNATURE OF REGISTRAR <i>John A. Harrison</i>		14. SIGNATURE OF CLERK <i>John A. Harrison</i>		15. SIGNATURE OF JURY <i>John A. Harrison</i>	
16. SIGNATURE OF JURY <i>John A. Harrison</i>		17. SIGNATURE OF JURY <i>John A. Harrison</i>		18. SIGNATURE OF JURY <i>John A. Harrison</i>	
19. SIGNATURE OF JURY <i>John A. Harrison</i>		20. SIGNATURE OF JURY <i>John A. Harrison</i>		21. SIGNATURE OF JURY <i>John A. Harrison</i>	
22. SIGNATURE OF JURY <i>John A. Harrison</i>		23. SIGNATURE OF JURY <i>John A. Harrison</i>		24. SIGNATURE OF JURY <i>John A. Harrison</i>	
25. SIGNATURE OF JURY <i>John A. Harrison</i>		26. SIGNATURE OF JURY <i>John A. Harrison</i>		27. SIGNATURE OF JURY <i>John A. Harrison</i>	
28. SIGNATURE OF JURY <i>John A. Harrison</i>		29. SIGNATURE OF JURY <i>John A. Harrison</i>		30. SIGNATURE OF JURY <i>John A. Harrison</i>	
31. SIGNATURE OF JURY <i>John A. Harrison</i>		32. SIGNATURE OF JURY <i>John A. Harrison</i>		33. SIGNATURE OF JURY <i>John A. Harrison</i>	
34. SIGNATURE OF JURY <i>John A. Harrison</i>		35. SIGNATURE OF JURY <i>John A. Harrison</i>		36. SIGNATURE OF JURY <i>John A. Harrison</i>	
37. SIGNATURE OF JURY <i>John A. Harrison</i>		38. SIGNATURE OF JURY <i>John A. Harrison</i>		39. SIGNATURE OF JURY <i>John A. Harrison</i>	
40. SIGNATURE OF JURY <i>John A. Harrison</i>		41. SIGNATURE OF JURY <i>John A. Harrison</i>		42. SIGNATURE OF JURY <i>John A. Harrison</i>	
43. SIGNATURE OF JURY <i>John A. Harrison</i>		44. SIGNATURE OF JURY <i>John A. Harrison</i>		45. SIGNATURE OF JURY <i>John A. Harrison</i>	
46. SIGNATURE OF JURY <i>John A. Harrison</i>		47. SIGNATURE OF JURY <i>John A. Harrison</i>		48. SIGNATURE OF JURY <i>John A. Harrison</i>	
49. SIGNATURE OF JURY <i>John A. Harrison</i>		50. SIGNATURE OF JURY <i>John A. Harrison</i>		51. SIGNATURE OF JURY <i>John A. Harrison</i>	
52. SIGNATURE OF JURY <i>John A. Harrison</i>		53. SIGNATURE OF JURY <i>John A. Harrison</i>		54. SIGNATURE OF JURY <i>John A. Harrison</i>	
55. SIGNATURE OF JURY <i>John A. Harrison</i>		56. SIGNATURE OF JURY <i>John A. Harrison</i>		57. SIGNATURE OF JURY <i>John A. Harrison</i>	
58. SIGNATURE OF JURY <i>John A. Harrison</i>		59. SIGNATURE OF JURY <i>John A. Harrison</i>		60. SIGNATURE OF JURY <i>John A. Harrison</i>	
61. SIGNATURE OF JURY <i>John A. Harrison</i>		62. SIGNATURE OF JURY <i>John A. Harrison</i>		63. SIGNATURE OF JURY <i>John A. Harrison</i>	
64. SIGNATURE OF JURY <i>John A. Harrison</i>		65. SIGNATURE OF JURY <i>John A. Harrison</i>		66. SIGNATURE OF JURY <i>John A. Harrison</i>	
67. SIGNATURE OF JURY <i>John A. Harrison</i>		68. SIGNATURE OF JURY <i>John A. Harrison</i>		69. SIGNATURE OF JURY <i>John A. Harrison</i>	
70. SIGNATURE OF JURY <i>John A. Harrison</i>		71. SIGNATURE OF JURY <i>John A. Harrison</i>		72. SIGNATURE OF JURY <i>John A. Harrison</i>	
73. SIGNATURE OF JURY <i>John A. Harrison</i>		74. SIGNATURE OF JURY <i>John A. Harrison</i>		75. SIGNATURE OF JURY <i>John A. Harrison</i>	
76. SIGNATURE OF JURY <i>John A. Harrison</i>		77. SIGNATURE OF JURY <i>John A. Harrison</i>		78. SIGNATURE OF JURY <i>John A. Harrison</i>	
79. SIGNATURE OF JURY <i>John A. Harrison</i>		80. SIGNATURE OF JURY <i>John A. Harrison</i>		81. SIGNATURE OF JURY <i>John A. Harrison</i>	
82. SIGNATURE OF JURY <i>John A. Harrison</i>		83. SIGNATURE OF JURY <i>John A. Harrison</i>		84. SIGNATURE OF JURY <i>John A. Harrison</i>	
85. SIGNATURE OF JURY <i>John A. Harrison</i>		86. SIGNATURE OF JURY <i>John A. Harrison</i>		87. SIGNATURE OF JURY <i>John A. Harrison</i>	
88. SIGNATURE OF JURY <i>John A. Harrison</i>		89. SIGNATURE OF JURY <i>John A. Harrison</i>		90. SIGNATURE OF JURY <i>John A. Harrison</i>	
91. SIGNATURE OF JURY <i>John A. Harrison</i>		92. SIGNATURE OF JURY <i>John A. Harrison</i>		93. SIGNATURE OF JURY <i>John A. Harrison</i>	
94. SIGNATURE OF JURY <i>John A. Harrison</i>		95. SIGNATURE OF JURY <i>John A. Harrison</i>		96. SIGNATURE OF JURY <i>John A. Harrison</i>	
97. SIGNATURE OF JURY <i>John A. Harrison</i>		98. SIGNATURE OF JURY <i>John A. Harrison</i>		99. SIGNATURE OF JURY <i>John A. Harrison</i>	
100. SIGNATURE OF JURY <i>John A. Harrison</i>		101. SIGNATURE OF JURY <i>John A. Harrison</i>		102. SIGNATURE OF JURY <i>John A. Harrison</i>	

*John A. Harrison*

## 6048 CERTIFICATE OF DEATH

Reg. Dist. No. 06057

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. St. Hospital</u>				d. STREET ADDRESS <u>Middletown</u> <u>10 X - 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Naomi</u> Last <u>Keller</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/10/1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bookkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>wholesale co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Daniel Rupley Keller</u>				14. MOTHER'S MAIDEN NAME <u>Jeannetta Routzahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Harry C. Keller, Middletown, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>communicating hydrocephalus</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uncinate Hernia</u> DUE TO (c) <u>bilateral infarction of occipital lobe</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u> <u>7 mos.</u> <u>8 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atelectasis, bilateral, pulmonary congestion and edema</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>OCTOBER 9, 1958</u> , to <u>May 9, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor L. Ramos</u>				ADDRESS (Street, city or town, state) <u>Western Md. State Hospital</u> DATE SIGNED <u>May 19, 1959</u>			
PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/12/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6098

## CERTIFICATE OF DEATH

06058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALE WAY</u>		c. LENGTH OF STAY IN 1b <u>16 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1828 HEISTER BORO ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT - HAWKINS - KEPLER</u>		4. DATE OF DEATH Month Day Year <u>MAY - 5 - 19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH - 2 - 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>2 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HILLSIDE COAL CO</u>	
11. BIRTHPLACE (State or foreign country) <u>NR. MIDDLETOWN FRED CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN H. KEPLER</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN R. AHALT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>220-16-1913</u>	
17. INFORMANT <u>MRS. CATHERINE S. KEPLER</u>		Address <u>1828 HEISTER BORO RD. HALE WAY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic myocardial heart disease</u> DUE TO <u>Advanced generalized vascular arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>50</u> , to <u>May 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>59</u> , and that death occurred at <u>9:35 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u>	
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>		DATE SIGNED <u>5-5-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 8 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MIDDLETOWN FRED CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 59</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

EXHIBIT B-1

<p>1. Name of deceased: <i>Robert A. Jones</i></p>	
<p>2. Date of death: <i>April 15, 1968</i></p>	
<p>3. Place of death: <i>Home</i></p>	
<p>4. Cause of death: <i>Heart Disease</i></p>	
<p>5. Manner of death: <i>Natural</i></p>	
<p>6. Age at death: <i>65</i></p>	
<p>7. Sex: <i>Male</i></p>	
<p>8. Race: <i>White</i></p>	
<p>9. Marital status: <i>Married</i></p>	
<p>10. Occupation: <i>Engineer</i></p>	
<p>11. Usual residence: <i>123 Main St., Baltimore, Md.</i></p>	
<p>12. Signature of physician: <i>[Signature]</i></p>	
<p>13. Signature of registrar: <i>[Signature]</i></p>	

6049

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 Mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>204 Summer St</b>			d. STREET ADDRESS <b>204 Summer st</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>GAYNELLE MAY KETCHENS</b>			4. DATE OF DEATH Month Day Year <b>May 3 1959 19</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>July 2 1927</b>	9. AGE (in years last birthday) <b>31</b> yrs.	IF UNDER 1 YEAR Months Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switch Board Operator State Hospital Hagerstown Wash. Co</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Carl Kidwell</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Smith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Robert H. Ketchens 204 Summer st</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Air Embolism rt. auricle of heart</b> <b>650.2</b> DUE TO <b>( Air introduced into uterine sinuses )</b> Conditions, if any, which gave rise to immediate cause (b) <b>Sudden death</b> (a), stating the underlying cause last, DUE TO (c) <b>Sudden death</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> 19. WAS AUTOPSY PERFORMED? <b>Pregnancy about 12 weeks gestation</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Attempt self induced abortion by injecting air into uterine cavity.</b>			
20c. TIME OF INJURY Hour Minute <b>10:00 PM</b>	Month, Day, Year <b>5-3 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Hagerstown</b>	(County) (State) <b>Wash Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5-4-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Men. Gardens Hagerstown Wash. Co Md</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>			24a. REC'D BY REGISTRAR DATE <b>MAY 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1045

STATE OF MASSACHUSETTS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Date of Death		Time of Death		Place of Death		Cause of Death	
Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report		Cause of Report	
Manner of Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Final Report		Time of Final Report		Place of Final Report		Cause of Final Report	
Manner of Final Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06060

6050 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOONSBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>POTOMAC ST.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL PIERCE KING</u>				4. DATE OF DEATH Month Day Year <u>MAY - 14 19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY - 31 - 1897</u>	
9. AGE (In years last birthday) yrs. <u>61</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>9 13</u>		IF UNDER 24 HRS. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - LIVESTOCK DEALER - SALES CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OTTO W. KING</u>				14. MOTHER'S MAIDEN NAME <u>LOLLIE SUMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-36-6325</u>		17. INFORMANT <u>MRS. MARTHA KING BOONSBORO MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>59</u> , to <u>May 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>59</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Livan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u>		DATE SIGNED <u>5/15/59</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Livan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bost</u> ADDRESS <u>Boonsboro MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

2125 - CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENT

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6099 CERTIFICATE OF DEATH

06061

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>				c. LENGTH OF STAY IN 1b <b>4 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanitarium</b>				d. STREET ADDRESS <b>417 N. Potomac Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ETHEL</b> Last <b>KOHLER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 18, 1878</b>		9. AGE (In years lost birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pomeroy, Ohio</b>	
13. FATHER'S NAME <b>Milton Kohler</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bittinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-32-5688A</b>		17. INFORMANT <b>Harry B. Kohler</b>		Address <b>Hagerstown Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive vascular disease</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>5 yrs.</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Feb 3, 1945</b> to <b>May 9, 1959</b> , that I last saw the deceased alive on <b>May 3, 1959</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. <b>May 9th</b> ADDRESS (Street, city or town, state) <b>214 N. Potomac st.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>				M.D. <b>214 N. Potomac st.</b>			
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman M. D.</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

# STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

Form No. 10-1-32

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		10-15-32	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		123 Main St., Birmingham		Heart Disease		Natural	
Occupation		Education		Marital Status		Social History	
Teacher		High School		Married		No	
Previous Illnesses		Drugs Taken		Alcohol Consumption		Tobacco Use	
None		None		Occasional		Occasional	
Burial Place		Funeral Home		Physician		Coroner	
Greenwood Cemetery		Doe & Sons		Dr. Smith		Mr. Jones	
Date of Burial		Signature of Physician		Signature of Coroner		Signature of Registrar	
10-20-32		[Signature]		[Signature]		[Signature]	

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		10-15-32	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		123 Main St., Birmingham		Heart Disease		Natural	
Occupation		Education		Marital Status		Social History	
Teacher		High School		Married		No	
Previous Illnesses		Drugs Taken		Alcohol Consumption		Tobacco Use	
None		None		Occasional		Occasional	
Burial Place		Funeral Home		Physician		Coroner	
Greenwood Cemetery		Doe & Sons		Dr. Smith		Mr. Jones	
Date of Burial		Signature of Physician		Signature of Coroner		Signature of Registrar	
10-20-32		[Signature]		[Signature]		[Signature]	

## 6100 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>				d. STREET ADDRESS <b>18 W. Baltimore Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CLARA</b>		First <b>ZEIGLER</b>		Last <b>LANE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1959</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1893</b>		
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Rouzeville, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rufus Zeigler</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Patterson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT <b>Mrs. Agnes Shirk</b> Address <b>Clearspring, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Uterus</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Oct 1958</b> to <b>May 28, 1959</b> , that I last saw the deceased alive on <b>May 27, 1959</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.				ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>5/29/59</b>				
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/29/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BUREAU OF CERTIFICATE OF DEATH		Washington, D.C.	
Name of Deceased John Doe		Date of Death April 1, 1953	
Sex Male		Age 65	
Race White		Marital Status Married	
Usual Residence 123 Main St., N.W. Washington, D.C.		Place of Death Home	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Signature J. Smith, M.D.		Registrar's Signature A. Jones	
Date of Report April 5, 1953		Report Made By Physician	

This certificate is to be filed in the office of the Registrar of the Department of Health, Bureau of Vital Statistics, Washington, D.C., and a copy is to be furnished to the local health officer.

## 6051 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>ONE WEEK</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X ZITTESTOWN RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. CO. HOSPITAL</b>				d. STREET ADDRESS <b>BOONSBORO MD. R. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>LUTHER</b> Last <b>LAPOLE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 27 - 1878</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ROAD DEPARTMENT</b>		11. BIRTHPLACE (State or foreign country) <b>ZITTESTOWN WASH. CO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM LAPOLE</b>			
14. MOTHER'S MAIDEN NAME <b>LANA RENT</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>- NO -</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>220-09-9764</b>				17. INFORMANT <b>MRS. MAZZY LAPOLE</b> Address <b>BOONSBORO MD. R. 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>490X Lobar PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <b>5-16-1959</b> , to <b>5-29-1959</b> , that I last saw the deceased alive on <b>5-29-1959</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>J. H. Sewidari</b> M.D. _____				PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 1 - 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ZITTESTOWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ZITTESTOWN WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Bast</b> ADDRESS <b>BOONSBORO MD.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MICHIGAN DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS DIVISION OF VITAL RECORDS

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## 6101 CERTIFICATE OF DEATH

Reg. Dist. No.

06064

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Etti</b> First <b>Idella</b> Middle <b>Lewis</b> Last		4. DATE OF DEATH <b>May 21,</b> Month <b>19</b> Day <b>59</b> Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1878</b>
9. AGE (In years at birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wolfsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Peter Tracey</b>		14. MOTHER'S MAIDEN NAME <b>Ida Kendel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>nono</b>	
17. INFORMANT <b>Mr. Keller Lewis, Cavetown, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Sclerosis</b> <b>334X</b> DUE TO <b>Cerebral Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 4, 1958</b> to <b>May 21, 1959</b> , that I lost s/he the deceased alive on <b>May 20, 1959</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		ADDRESS (Street, city or town, state) <b>Clear Spring Md</b> DATE SIGNED <b>5/22/59</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		<b>Clear Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>May 23, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Garfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06065

6052

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>50 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>739 W. WASHINGTON ST.</b>		d. STREET ADDRESS <b>739 W. WASHINGTON ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>KATHRYNE</b> Last <b>LUMM</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/ 5/ 1880</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEVI MIDDLEKAUFF</b>		14. MOTHER'S MAIDEN NAME <b>SALLIE GROVE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. CHAS. M. LUMM JR.</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cerebro Vascular Dis.</b> (c) <b>10 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 hours</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-21-1958</b> to <b>5-21-1958</b> , that I last saw the deceased alive on <b>5-21-1958</b> and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. E. W. Duth</b> M.D. <b>Hagerstown Md</b> DATE SIGNED <b>5-21-58</b> PHYSICIAN'S NAME (Type) <b>J. E. W. Duth</b> <b>Hagerstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

3202

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO BE COMPLETED BY THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6053 CERTIFICATE OF DEATH

06066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>50 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>17 BURGER AVE.</b>			
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>FRANCES</b> Last <b>LYNCH</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/1896</b>		9. AGE (In years lost birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>HARPERS FERRY W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES ALLEN</b>				14. MOTHER'S MAIDEN NAME <b>CLARA LEIGH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. ADAM LYNCH</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>nephrosclerosis</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalised arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>50</b> , to <b>May 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 9</b> , 19 <b>59</b> , and that death occurred at <b>1:10 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robt V. L. Campbell</b>		M.D. <b>145 W Washington St Hagerstown Md</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>5/11/59</b>	
PHYSICIAN'S NAME (Type) <b>Robt. V. L. Campbell M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	



## 6054 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		d. STREET ADDRESS <b>205 Manse Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Elwood</b> Last <b>Malotte</b>		4. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1919</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sewerage operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Hagerstown</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Malotte</b>		14. MOTHER'S MAIDEN NAME <b>Georgetta Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>620-09-8826</b>	
17. INFORMANT <b>Mrs. Jane L. Malotte</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/5/59</b> to <b>5/6/59</b> , that I last saw the deceased alive on <b>5/5/59</b> , 19 <b>59</b> , and that death occurred at <b>8:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Ralph Young</b> M.D. <b>5/7/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krauss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>R # 2</b>	
3. NAME OF DECEASED (Type or print) First <b>Olen</b> Middle <b>Glenn</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1948</b>
9. AGE (In years last birthday) <b>10</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Russell Martin</b>		14. MOTHER'S MAIDEN NAME <b>Lou Diller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Russell Martin - R # 2 Hagerstown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest; Hemorrhage and shock</b> <b>835X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell under tractor that overturned while he was operating it</b>	
20c. TIME OF INJURY Hour <b>5:30</b> p.m. Month, Day, Year <b>May 22 1959</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Rural- Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DATE SIGNED <b>5-23-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Salem Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Greencastle Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. E. Minnick</b>		ADDRESS <b>Greencastle, Pa.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clifton S. Kraus</b>	

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MEDICAL CERTIFICATION

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# MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRATION DIVISION MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Name]		SEX [Male/Female]	
DATE OF BIRTH [Date]		PLACE OF BIRTH [Location]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]	
PLACE OF DEATH [Location]		TIME OF DEATH [Time]	
NAME OF PHYSICIAN [Name]		NAME OF MEDICAL EXAMINER [Name]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF MEDICAL EXAMINER [Signature]	
DATE OF EXAMINATION [Date]		TIME OF EXAMINATION [Time]	
PLACE OF EXAMINATION [Location]		NAME OF HOSPITAL [Name]	
NAME OF NURSE [Name]		NAME OF ATTENDING PHYSICIAN [Name]	
SIGNATURE OF NURSE [Signature]		SIGNATURE OF ATTENDING PHYSICIAN [Signature]	
DATE OF SIGNATURE [Date]		TIME OF SIGNATURE [Time]	
PLACE OF SIGNATURE [Location]		NAME OF HOSPITAL [Name]	
NAME OF NURSE [Name]		NAME OF ATTENDING PHYSICIAN [Name]	
SIGNATURE OF NURSE [Signature]		SIGNATURE OF ATTENDING PHYSICIAN [Signature]	
DATE OF SIGNATURE [Date]		TIME OF SIGNATURE [Time]	
PLACE OF SIGNATURE [Location]		NAME OF HOSPITAL [Name]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6056

CERTIFICATE OF DEATH

06069

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>62 East Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>RICHARD</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1903</b>		9. AGE (In years lost birthday) <b>55 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cargo Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Z. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Ida Reid</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>705-10-7490</b>		17. INFORMANT <b>Mrs. Katherine Martin</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease with angina</b> DUE TO <b>Acute myocardial failure with pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 1 day</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Jan 19 57</b> to <b>16 May 19 59</b> , that I last saw the deceased alive on <b>16 May 19 59</b> , and that death occurred at <b>9 50 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Potomac St Hagerstown</b>		DATE SIGNED <b>18 May 59</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/19/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06070

6057

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>no street address</b>	
3. NAME OF DECEASED (Type or print) <b>ALONZA</b> First <b>C.</b> Middle <b>MILLER</b> Last		4. DATE OF DEATH <b>May</b> Month <b>19</b> Day <b>59</b> Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1884</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Track Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Markes, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Miller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Werdebaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>716-09-4888</b>	
17. INFORMANT <b>Mrs. Elizabeth P. Miller</b>		Address <b>Marion, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>19 May</b> , 19 <b>57</b> , and that death occurred at <b>3:30 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>20 May 57</b>	
PHYSICIAN'S NAME (Type) <b>[Signature]</b>		M.D. <b>GREENCASTLE, PA</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/22/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chambersburg, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Ringer</b>		ADDRESS <b>Hagerstown, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

7-1-1957

11. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

[illegible]

NOTES

1991, 1992, 1993

b7E12b

*[Faint, illegible text]*

097-6038

[illegible]

or

102

6058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>20 min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Wash</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W3 Hagerstown</b> d. STREET ADDRESS <b>8C - Longwood Apt.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Miller, Sharon Lynn</b>		4. DATE OF DEATH Month Day Year <b>May 12 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1959</b>
9. AGE (In years lost birthday) yrs. <b>25</b>		10. IF UNDER 1 YEAR Months Days Hours <b>25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ronald Hugh Miller</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Caraway Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>771.5 Immaturity</b> DUE TO (b) <b>Intra partum hemorrh</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-12-59</b> , to <b>5-12-59</b> , that I last saw the deceased alive on <b>5-12-59</b> , and that death occurred at <b>2:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>302 N. POTOMAC ST HAGERSTOWN MD</b> DATE SIGNED <b>5-15-59</b> ACTUAL SIGNATURE <b>John D. Turco</b> M.D. PHYSICIAN'S NAME (Type) <b>JOHN D. TURCO</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington County Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Rands</b>		ADDRESS <b>2081181XVO</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

MEDICAL CERTIFICATION



## 6102 CERTIFICATE OF DEATH

06072

Reg. Dist. No.

1. PLACE OF DEATH <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Clear Spring, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Clear Spring, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 2 Clear Spring, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry Calvin Mills</b>		4. DATE OF DEATH Month Day Year <b>May 27th 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 24, 1912</b>
9. AGE (In years lost birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>47</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sawmill</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Amos Calvin Mills</b>		14. MOTHER'S MAIDEN NAME <b>Lela Mae Mills Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>220-09-7526</b>	
17. INFORMANT <b>Susan Pauline Mills (Wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema of Lungs</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Cardiac Failure</b> DUE TO (c) <b>Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15, 1959</b> to <b>May 28, 1959</b> that I last saw the deceased alive on <b>May 28, 1959</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>5/29/59</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Paul Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Clear Spring, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b> Clear Spring, Maryland		24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

NAME: [illegible] RESIDENCE: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible]

DATE OF EXHUMATION: [illegible] PLACE OF EXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6103

## CERTIFICATE OF DEATH

Reg. Dist. No.

06073

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BIG SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BIG SPRING</b>	
c. LENGTH OF STAY IN 1b <b>14 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>COVE ROAD</b>		d. STREET ADDRESS <b>COVE ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CALVIN</b> Last <b>MONGAN</b>		4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 12, 1886</b>
9. AGE (In years, App. birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA. R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH MONGAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY McDANIEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. ROSE MONGAN</b>		Address <b>BIG SPRING RT I, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Endocarditis</b> <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 19 59</b> to <b>May 25 19 59</b> , that I last saw the deceased alive on <b>May 24, 19 59</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>5/25/59</b> ACTUAL SIGNATURE <b>David R. Brewer M.D.</b> PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6104

## CERTIFICATE OF DEATH

06074

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CASCADE</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CASCADE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>				d. STREET ADDRESS <b>RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>G.</b> Last <b>MOORE JR.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1882</b>	9. AGE (In years, last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, R.R. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-198-05-7550</b>		11. BIRTHPLACE (State or foreign country) <b>Cascade Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Moore</b>				14. MOTHER'S MAIDEN NAME <b>Mary J. Royer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>198-05-7550</b>		17. INFORMANT <b>Carl Moore, 37 North Gaston Ave., Samerville N.J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA HEAD OF PANCREAS</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old age</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 Months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Jan. 1948</b> to <b>May 21, 1959</b> , that I last saw the deceased alive on <b>May 21, 1959</b> , and that death occurred at <b>7:22 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethel, Pa.</b> DATE SIGNED <b>21 May 59</b>							
ACTUAL SIGNATURE <b>Robert D. Shuford</b>				M.D. <b>Blue Ridge Summit, Pa.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		22d. LOCATION (City, town, or county) (State) <b>Lantz #1, Frederick Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Z. Stone</b>				ADDRESS <b>Haymarket, Pa.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 59</b>	
				DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6105 CERTIFICATE OF DEATH

06075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>		c. LENGTH OF STAY IN 1b <u>6 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MERCERSBURG, PA. 75 x 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>				d. STREET ADDRESS <u>R.#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>SUSAN</u> Last <u>NEGLEY</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 21, 1914</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HEMASTERS, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CLARENCE H. NEGLEY</u>				14. MOTHER'S MAIDEN NAME <u>RHODA GRABILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>175-03-246</u>		17. INFORMANT Name <u>Mrs. Rhoda S. Negley</u> Address <u>Mercersburg, Pa. R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> <u>355x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypochalimia</u> DUE TO <u>distraction</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>May 26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.E. Byrkit</u>				DATE SIGNED <u>5/27/59</u>			
PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>				ADDRESS (Street, city or town, state) <u>28 W Potomac</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upton BRETHERN Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>MERCERSBURG, PA. R. 2</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. L. Linnigan</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

# CERTIFICATE OF DEATH

1-1-58-111

PLACE OF BIRTH

RESIDENCE

DATE OF DEATH

CLASS OF DEATH  
NATURAL  
SUICIDE  
HOMICIDE

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6059 CERTIFICATE OF DEATH

Reg. Dist. No.

06076

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Playertown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>Marion, Pa.</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin HARVEY OCKER</u>		4. DATE OF DEATH <u>MAY 19 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 25, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abram W. Ocker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Ricker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>C.R. Ocker</u>		Address <u>Maugansville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>May 6, 1959 (13 days)</u> <u>20 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1939</u> , 19____, to <u>5/19/59</u> , 19____, that I last saw the deceased alive on <u>5/19/59</u> , 19____, and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Brewer</u>		ADDRESS (Street, city or town, state) <u>359 E. Baltimore St.</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Brewer, M.D.</u>		DATE SIGNED <u>5/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Marion, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6060

## CERTIFICATE OF DEATH

Reg. Dist. No.

06077

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN <u>3 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>6 S. Conococheague</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lester</u> Last <u>O'Neil</u>		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1908</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	11. IF UNDER 24 HRS. Hours <u>5</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>New Lexington, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Edward O'Neil</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Jones Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>8-217-10-688</u>	
17. INFORMANT <u>Mrs. Virginia O'Neil Wmpt, Md</u>		Address <u>Williamsport, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/3/59</u> , 19 <u>59</u> , to <u>5/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/3</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M Byrkit</u>		ADDRESS (Street, city or town, state) <u>28 W. Potomac St Williamsport, Md</u>	
DATE SIGNED <u>5/4/59</u>			
PHYSICIAN'S NAME (Type) <u>MAX BYRKIT, M.D.</u>		<u>Williamsport, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 6 - 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis E. Hume</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06078

6061

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Rohrersville, Md. R#2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>EUGENE</b> Last <b>PERKINS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1952</b>		9. AGE (In years last birthday) <b>6 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elmer Lester Perkins</b>				14. MOTHER'S MAIDEN NAME <b>Marjorie M. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Elmer L. Perkins</b> Address <b>Rohrersville, Md. R#2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tetanus</b> <b>936.0</b> DUE TO <b>Accidental amputation of tip of rt. index finger</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Caught finger in Sprocket of bicycle</b>					
20c. TIME OF INJURY Hour <b>7</b> p. m. Month, Day, Year <b>May 16 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rural Rohrersville Wash, Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-1-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 3 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

1001

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

40028

<p>1. Name of deceased: _____</p>	
<p>2. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Manner of death: _____</p>	
<p>8. Signature of Medical Examiner: _____</p>	
<p>9. Signature of Coroner: _____</p>	
<p>10. Signature of Registrar: _____</p>	
<p>11. Signature of Physician: _____</p>	
<p>12. Signature of Family: _____</p>	
<p>13. Signature of Burial: _____</p>	
<p>14. Signature of Cremation: _____</p>	
<p>15. Signature of Other: _____</p>	

## 6062 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>45 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>814 Potomac Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Ernst Plack</b>				4. DATE OF DEATH <b>May 2 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1887</b>	
9. AGE (In years lost birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Harrisburg Pa.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Otto Plack</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Zinn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-09-3232</b>			
17. INFORMANT <b>Mrs. Grace E. Plack</b>				Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 yrs</b> DUE TO (c) <b>5 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11-27, 1957</b> to <b>5-2-1959</b> that I last saw the deceased alive on <b>5-1-59</b> , 19, and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. W. Ditto Jr.</b>				ADDRESS (Street, city or town, state) <b>215 W. Washington St</b>			
DATE SIGNED <b>5-3-59</b>							
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto Jr.</b>				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. M innich &amp; Son Hagerstown</b>				ADDRESS <b>d.</b>		24a. REC'D BY REGISTRAR <b>MAY 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000 CERTIFICATE OF DEATH

Washington Maryland Washington

Washington 42 years Washington

814 Potomac Ave. 814 Potomac Ave.

Male White Charles Black 28

June 14, 1887 VI

Wife President Mrs. G.

Black Black Elizabeth Black

214-02-3232 Mrs. Grace H. Black Washington D.C.

212 W. Washington St

Howard W. White Jr. Washington D.C.

2-2-22 Home Hill Cemetery Washington D.C.

George P. Hamilton & Son Washington D.C.

6063 CERTIFICATE OF DEATH

06080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Route 3</b>				c. LENGTH OF STAY IN 1b <b>6 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alvaretta</b> Middle <b>Poffenberger</b> Last				4. DATE OF DEATH Month <b>5</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1872</b>	
9. AGE (In years lost birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George W. Corby</b>				14. MOTHER'S MAIDEN NAME <b>Helen V. Kershner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT Address <b>Mrs. Ira M. Pike Hagerstown, Md. Route 3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombus</b> 332X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b> <b>Indefinite</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the vulva</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb. 15</b> , 19 <b>59</b> , to <b>May 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 6</b> , 19 <b>59</b> , and that death occurred at <b>5:45 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>148 West Washington St. 5/20/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B. B. Kneisley</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>River View</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

8063 DEPARTMENT OF HEALTH

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## 6064 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>23 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLARD</b> Middle <b>CHARLES</b> Last <b>RANCK</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1909</b>		9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool &amp; Die Maker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Danville, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>David F. Ranck</b>				14. MOTHER'S MAIDEN NAME <b>May Alice Rudy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>173-09-784</b>		17. INFORMANT <b>Mrs. Willard C. Ranck</b>		Address <b>22 Broadway Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized visceral Cancer</b> <b>154X</b> DUE TO <b>Rectal Adeno Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Unknown</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1939</b> , 19____, to <b>5/11/59</b> , 19____, that I last saw the deceased alive on <b>5/11/59</b> , 19____, and that death occurred on <b>10/30/59</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>SEARL YOUNG</b> M.D.				ADDRESS (Street, city or town, state) <b>148 M. Potomac Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>SEARL YOUNG M.D.</b>				DATE SIGNED <b>5/13/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. Host C-Pres.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>1930-01-15</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>New York, N.Y.</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>		<p>7. MARITAL STATUS</p> <p><i>Married</i></p>		<p>8. DATE OF MARRIAGE</p> <p><i>1955-06-10</i></p>	
<p>9. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>10. MANNER OF DEATH</p> <p><i>Natural</i></p>		<p>11. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>12. DATE OF DEATH</p> <p><i>1975-03-20</i></p>	
<p>13. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>15. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>17. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>19. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>21. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>22. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>23. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>25. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>27. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>28. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>29. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>31. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>33. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>34. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>35. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>37. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>39. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>40. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>41. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>43. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>45. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>46. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>47. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>49. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>51. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>52. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>53. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>54. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>55. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>57. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>58. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>59. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>60. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>61. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>63. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>64. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>65. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>67. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>68. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>69. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>70. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>71. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>73. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>74. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>75. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>76. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>77. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>79. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>80. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>81. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>82. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>83. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>85. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>87. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>88. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>89. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>91. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>93. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>94. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>95. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	
<p>97. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>98. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>99. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>100. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>	



THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC FOR A FEE OF FIVE CENTS PER COPY. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

## 6065 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>45 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>841 Guilford Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Theodore Grayson Reeder Sr.</b>				4. DATE OF DEATH <b>May 28 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 31, 1903</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sand Blast</b>		11. BIRTHPLACE (State or foreign country) <b>Near Boonesboro Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Jacob F. Reeder</b>				14. MOTHER'S MAIDEN NAME <b>Nellie M. Longanecker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-5294</b>			
INFORMANT <b>Mrs. Florence Reeder</b>				Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>24 May, 1959</b> to <b>28 May, 1959</b> , that I last saw the deceased alive on <b>28 May, 1959</b> , and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. D. Wilson</b>				ADDRESS (Street, city or town, state) <b>135 N. Potomac St. Hagerstown Md.</b>		DATE SIGNED <b>5/29/59</b>	
PHYSICIAN'S NAME (Type) <b>J. D. Wilson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 2 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6068 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>78 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1315 Oak Hill Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>ROY</b> Last <b>REICHARD</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1880</b>	
9. AGE (In years last birthday) <b>78 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing Supply Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Daniel W Reichard</b>			
14. MOTHER'S MAIDEN NAME <b>Angella L Wolf</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>220-30-9573</b>				17. INFORMANT <b>Daniel L Reichard</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart block due to arteriosclerosis</b> <b>433.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Emphysema</b> (c) <b>E</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophic arthritis generalized.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b> <b>5-10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month <b>May</b> Day <b>18</b> Year <b>1959</b> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>May 18, 1959</b> to <b>May 18, 1959</b> , that I last saw the deceased alive on <b>May 18, 1959</b> , and that death occurred at <b>12 noon</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert F Keadle</b> M.D.				ADDRESS (Street, city or town, state) <b>318 N. Potomac St. Hagerstown, Maryland</b>			
DATE SIGNED <b>5-18-59</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5/20/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Hagerstown Maryland</b>				22e. (State) <b>Maryland</b>		22f. (County) <b>Maryland</b>	
23. FUNERAL HOME <b>Shades Funeral Home</b>				ADDRESS <b>Hagerstown Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 20 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>				24c. (City, town, or county) <b>Hagerstown Maryland</b>		24d. (State) <b>Maryland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6106 CERTIFICATE OF DEATH

06084

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Knoxville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weverton Hill</b>		d. STREET ADDRESS <b>Weverton Hill</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Hanson</b> Middle <b>Rickerds</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1889</b>
9. AGE (In years and birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Give if retired) <b>Retired railroader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Garrotts Mill, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George H. Rickerds</b>		14. MOTHER'S MAIDEN NAME <b>Mary Martin Rickerds</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Edith Rickerds</b>		Address <b>Knoxville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Dectusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>15659</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>15659</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/17</b> , 19 <b>59</b> to <b>5/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/18</b> , 19 <b>59</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b> DATE SIGNED <b>5/19/59</b>			
ACTUAL SIGNATURE <b>Dr. J.G.F. Smith</b>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/21/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethern</b>	22d. LOCATION (City, town, or county) (State) <b>Brownsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olva V. Feete</b>		24a. REC'D BY REGISTRAR <b>Brunswick, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		DATE <b>MAY 25 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06085

## 6107 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R #1</b>		c. LENGTH OF STAY IN 1b <b>13 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hagerstown R # 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Black Rock</b>				e. STREET ADDRESS <b>Black Rock</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BEULAH EMMA RIDENOUR</b>				4. DATE OF DEATH Month Day Year <b>May 15 1959 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27 1910 48</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest Snodderly</b>				14. MOTHER'S MAIDEN NAME <b>Effie Wyant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Le Roy Ridenour Sr Hagerstown Md.</b>		Address <b>R#1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b> <b>331X</b> DUE TO <b>Vascular Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>none</b>			
20c. TIME OF INJURY Hour a. m. p. m. <b>none</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>46</b> to <b>May 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 1</b> , 19 <b>59</b> , and that death occurred at <b>P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>5-18-59</b> ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D. <b>115 N. Potomac Street</b> PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b> <b>Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
1905

**CERTIFICATE OF DEATH**

NAME: *James Edward*  
AGE: *35*  
SEX: *Male*  
RACE: *White*  
BIRTH: *Jan 15 1870*  
DEATH: *Jan 15 1905*  
PLACE OF BIRTH: *Massachusetts*  
PLACE OF DEATH: *Massachusetts*  
CAUSE OF DEATH: *Heart Disease*  
DISEASE: *Myocarditis*  
DIAGNOSIS: *Myocarditis*  
TREATMENT: *None*  
BURIAL: *None*  
SIGNATURE: *James Edward*  
DATE: *Jan 15 1905*

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6067 CERTIFICATE OF DEATH

06086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>70 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>JACKSON CONV. HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>JANE</b> Last <b>RINGER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/7/1878</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES PEARELL</b>	
14. MOTHER'S MAIDEN NAME <b>MARY SANDERS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>214-28-5876</b>		17. INFORMANT <b>MR. HOWARD C. RINGER</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Upper respiratory infection</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-28, 1942</b> , to <b>5-4, 1959</b> , that I last saw the deceased alive on <b>5-4, 1959</b> , and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>5:5:59</b>			
ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D.		154 West Washington St., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 7 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	



## 6068 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Williamsport RFD #1</b>	
3. NAME OF DECEASED (Type or print) <b>VICTOR HENRY ROBINSON</b>		4. DATE OF DEATH <b>May 1 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1909</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Emmanuel Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Essie Agnes Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-4198</b>	
17. INFORMANT <b>Mrs. Anna Mary Robinson</b>		18. ADDRESS <b>Williamsport, Md. RFD #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Brain</b> (c) <b>Day</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/25/59</b> to <b>5/1/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/1/59</b> , and that death occurred on <b>5/1/59</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert Young</b> M.D.		DATE SIGNED <b>5/1/59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Cem. Near Hagerstown, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Lee Williamsport, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Christina S. Kiana</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Washington, D.C.      Maryland      Virginia

Washington, D.C.      3 Weeks      Washington, D.C.

Washington, D.C.      Washington, D.C.      Washington, D.C.

Washington, D.C.      HENRY      VICTOR

Washington, D.C.      March 9, 1909      Washington, D.C.

Washington, D.C.      Washington, D.C.      Washington, D.C.

Washington, D.C.      Washington, D.C.      Washington, D.C.

Washington, D.C.      Washington, D.C.      Washington, D.C.

*William F. Johnson*

*William F. Johnson*

Washington, D.C.      Washington, D.C.      Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Items 2,11,15 Film G242 3-20-59 et  
**CERTIFICATE OF DEATH**

6069

06088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 Vol. 4</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1322 N. Calhoun Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>ROLLINS</u> Last <u>ROLLINS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unk.</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UREMIA</u> DUE TO (c) <u>MULTIPLE MYELOMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>UNKNOWN</u> <u>ABOUT 6 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL 17</u> 19 <u>59</u> , to <u>MAY 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 12</u> , 19 <u>59</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Beren</u> M.D.		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE.</u> DATE SIGNED <u>5/13/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. GEORGE BEREN</u>		<u>HAGERSTOWN, MARYLAND.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Mt Auburn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clifton Wherry</u> ADDRESS <u>2700 E. Howard St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>

REF



## 6070 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		1. d. STREET ADDRESS <b>413 Church Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>LORRAINE</b> Last <b>ROSER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1897</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Elmira, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilson Langle</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Pardon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>U. Earl Roser</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Gall bladder liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/1/6</b> 19 <b>59</b> to <b>5/29</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 29, 1959</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>159 W. Washington St. Hagerstown, Md. 6/2/59</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		<b>159 W. Washington St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/2/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouser Funeral Home</b>		ADDRESS <b>Hagerstown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUN 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton B. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

<p>1. Name of deceased                  William Henry Harrison</p>		<p>2. Sex                  Male</p>		<p>3. Age                  68 years</p>		<p>4. Date of death                  July 10, 1927</p>		<p>5. Place of death                  Boston, Mass.</p>		<p>6. Cause of death                  Coronary thrombosis</p>	
<p>7. Occupation                  Merchant</p>		<p>8. Usual residence                  123 North Street, Boston</p>		<p>9. Date of birth                  July 10, 1859</p>		<p>10. Place of birth                  New York</p>		<p>11. Name of physician                  Dr. J. H. Smith</p>		<p>12. Name of undertaker                  J. H. Smith</p>	
<p>13. Name of informant                  Mrs. William H. Harrison</p>		<p>14. Address of informant                  123 North Street, Boston</p>		<p>15. Signature of informant                  (Signature)</p>		<p>16. Signature of physician                  (Signature)</p>		<p>17. Signature of undertaker                  (Signature)</p>		<p>18. Signature of registrar                  (Signature)</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6071 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06090

Reg. Dist. No. 302

**FOR STATE  
HEALTH DEPT.**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>8 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>735 Virginia Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>735 Virginia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CHARLES</u> Middle <u>WILLIAM</u> Last <u>SEBURN</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>18</u> Year <u>1959</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 28 1911</u>		<b>9. AGE</b> (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Eyerlys Inc</u>		<b>11. BIRTHPLACE</b> (State and country) <u>Parkton Co Pa</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Howard Seburn</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Carbaugh</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <u>-----</u>		<b>17. INFORMANT</b> Address <u>Mrs Hazel Seburn 735 Virginia Ave Hagerstown Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> DUE TO <u>Gunshot Wound of face &amp; head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>instant</u> DUE TO <u>  </u> (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Suicide</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5-18-59</u> Hour <u>  </u> a. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>A. E. Coffman</u>				<b>DATE SIGNED</b> <u>7/14/59</u>					
<b>EXAMINER'S NAME (Type)</b> <u>DR F. W. H. T. T. T.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>5/22/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Hagerstown Wash Co Md</u> (State) <u>  </u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman Hagerstown Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAY 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Haines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is oriented horizontally but contains vertical text labels for various fields.

Fields include:

- Patient Name
- Age
- Sex
- Occupation
- Residence
- Place of Birth
- Date of Death
- Time of Death
- Place of Death
- Cause of Death
- Examiner's Signature
- Physician's Signature
- Medical History
- Physical Examination
- Autopsy
- Disposition of Body

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06091

6108

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>			c. LENGTH OF STAY IN 1b <u>17 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KEEDYSVILLE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>GROVER CLEVELAND SHUMAKER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MAY-18 19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 5-1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>7 13</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>ZITTLESTOWN WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MARTIN L. SHUMAKER</u>			
14. MOTHER'S MAIDEN NAME <u>ANNIE HUTZELL</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-22-9625</u>				17. INFORMANT <u>MRS. HESTER SHUMAKER KEEDYSVILLE MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>17 yrs.</u> <u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18</u> , 19 <u>59</u> , to <u>May 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>59</u> , and that death occurred at <u>3 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Bonnsboro, Ind.</u> DATE SIGNED <u>5/19/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-21-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SHARDSBURG WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u>				ADDRESS <u>BONNSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MAINE BOARD

CERTIFICATE OF DEATH

MAINE AND STATE DEPARTMENT OF HEALTH - BATHINGORE 19

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Registration		Place of Registration		County	
Municipality		Town		Range	
District		Section		Lot	
Block		Unit		Sub-unit	
Room		Apartment		Floor	
Building		Street		City	
State		Country		World	

FOR STATE  
HEALTH DEPT.

6072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06092

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>14 Elizabeth St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHLEEN</b> Middle <b>LUCILE</b> Last <b>SLATE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1908</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b>	IF UNDER 24 HRS. Hours <b>50</b> Min. <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph H. Martin</b>	
14. MOTHER'S MAIDEN NAME <b>Virgie B. Alexander</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robt. T. Slate Jr.</b> Address <b>19 Elizabeth St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b> DUE TO <b>Laceration of brain</b> Conditions, if any, which gave rise to immediate cause (b) <b>824X</b> (c), stating the underlying cause last. <b>824X</b> DUE TO <b>824X</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>824X</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of moving automobile</b>	
20c. TIME OF INJURY Hour <b>7:15</b> p. m. <b>May 18 19 59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Rural Dam # 5 Road- Wash Md</b> (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>5-22-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. A. Horst</b> ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>

MEDICAL CERTIFICATION

6032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-11-11

1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of death: Nov 11, 1911  
5. Place of death: Home  
6. Cause of death: Heart disease  
7. Manner of death: Natural  
8. Signature of examiner: [Signature]  
9. Date of examination: Nov 11, 1911

Signature of civil  
Sanitation of civil

10. Name of physician: Dr. J. Smith  
11. Address of physician: 123 Main St.  
12. Signature of physician: [Signature]  
13. Date of signature: Nov 11, 1911  
14. Name of coroner: John Doe  
15. Address of coroner: 456 Main St.  
16. Signature of coroner: [Signature]  
17. Date of signature: Nov 11, 1911  
18. Name of registrar: John Doe  
19. Address of registrar: 789 Main St.  
20. Signature of registrar: [Signature]  
21. Date of signature: Nov 11, 1911

## 6073 CERTIFICATE OF DEATH

Reg. Dist. No.

06093

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>1633 Fountainhead Road</b>	
3. NAME OF DECEASED (Type or print) First <b>DENTON</b> Middle <b>LEHMAN</b> Last <b>SNECKENBERGER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1897</b>
9. AGE (In years lost birthday) yrs. <b>62</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Reid, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Denton A. Sneckenberger</b>		14. MOTHER'S MAIDEN NAME <b>Grace Lehman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 214-09-8439</b>	
17. INFORMANT <b>Mrs. D.L. Sneckenberger</b>		Address <b>Hagerstown, Md.</b> <b>1633 Fountainhead Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Congestive Heart Failure on basis of Arteriosclerotic Cardiovascular disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>422.1</b> DUE TO (c) <b>15 months.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>About 15 months.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb.</b> 19 <b>58</b> to <b>May 27,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 27,</b> 19 <b>59</b> , and that death occurred at <b>5:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac Street Hagerstown, Maryland.</b> DATE SIGNED <b>5-29-59</b>			
ACTUAL SIGNATURE <b>R.A. Bell</b>		M.D. <b>119 North Potomac Street Hagerstown, Maryland.</b>	
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>		<b>Hagerstown, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6109 CERTIFICATE OF DEATH

06094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Rural 2 Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Conv. Home</u>		d. STREET ADDRESS <u>Carroll St. ext.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Aaron Spangler</u> First Middle Last		4. DATE OF DEATH <u>May 25, 1959</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1882</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broom mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pius Spangler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Klinefelter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-32-5206</u>	
17. INFORMANT <u>Arthur H. Spangler</u> Address <u>Thurmont, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 30 1959</u> to <u>May 24 1959</u> that I last saw the deceased alive at <u>May 24 1959</u> and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u> ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6074 CERTIFICATE OF DEATH

06095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>			
c. LENGTH OF STAY IN 1b <b>2 weeks</b>				d. STREET ADDRESS <b>1114 Pope Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George William Spence</b>				4. DATE OF DEATH Month Day Year <b>May 30 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20 1888</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (State or foreign country) <b>Shepherdstown W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George William Spence</b>				14. MOTHER'S MAIDEN NAME <b>Frances Bast</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 09 5860</b>		INFORMANT <b>Mrs. Ora Spence</b> Address <b>1114 Pope Ave. Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Cerebral Thrombosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Cerebral Thrombosis.						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate months - years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 13 1958</b> to <b>May 30 1959</b> , that I last saw the deceased alive on <b>May 30 1959</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				ADDRESS (Street, city or town, state) <b>159 W. Washington St. Hagerstown</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				DATE SIGNED <b>6/1/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CERTIFICATE OF DEATH

Washington

New York

George John 5 weeks Washington, D.C.

Washington State Hospital 1114 Ford Ave.

George William Spence 30 30

Sept. 20 1933 70 8 2

George William Spence Washington, D.C.

George William Spence Washington, D.C.

1114 Ford Ave.  
215 45 250 Ave. and Spence Washington, D.C.

George William Spence Washington, D.C.

George William Spence Washington, D.C.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06096

## 6075 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>10 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>217 Nottingham Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLYDE HERMAN SPRANKLE</b>				4. DATE OF DEATH Month Day Year <b>May 6 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 20 1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard M.P. Moller Co Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Rockdale Wash. Co Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Sanford Sprankle</b>		14. MOTHER'S MAIDEN NAME <b>Laura S. Shipp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>179-07-3408</b>		17. INFORMANT Address <b>Clyde R. Sprankle 2209 Virginia Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>446X</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO <b>Myocardial Infarction</b> (c) <b>Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>2 yrs.</b> <b>1 yr.</b> <b>6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 1950</b> to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 5, 1959</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				ADDRESS (Street, city or town, state) <b>159 W. Washington St. - Hagerstown, Md.</b>			
DATE SIGNED <b>5/6/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Date of death: <u>10/15/1951</u></p>	
<p>3. Place of death: <u>Home</u></p>		<p>4. Age: <u>65</u> years</p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>		<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of death: <u>Heart Disease</u></p>		<p>10. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>11. Contributing causes: <u>None</u></p>		<p>12. Manner of death: <u>Natural</u></p>	
<p>13. Signature of physician: <u>[Signature]</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	
<p>15. Date of registration: <u>10/16/1951</u></p>		<p>16. Place of registration: <u>Baltimore</u></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6076 CERTIFICATE OF DEATH

06097

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>R.F.D. # 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ELLSWORTH</b> Last <b>STONEBRAKER, SR.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1883</b>		
9. AGE (In years lost birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Dealer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jerome Ellsworth Stonebraker</b>				14. MOTHER'S MAIDEN NAME <b>Ella Heard</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>John E. Stonebraker, Jr.</b> Address <b>Hagerstown, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>minute</b> <b>hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate gland</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>April 27, 1959</b> to <b>May 14, 1959</b> , that I last saw the deceased alive on <b>May 14, 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St.</b> DATE SIGNED ACTUAL SIGNATURE <b>Clayton A. Hoffman M.D.</b> PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman Hagerstown, Md.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/16/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06098

6077 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cronic Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Agnes Allen Strathern</b>		4. DATE OF DEATH <b>5-29-1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Aramadale, Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Allan</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Nelson Allan Strathern, Brunswick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerosis, general</b> DUE TO <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Sigmoid Colon</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-31-1959</b> to <b>5-29-1959</b> , that I last saw the deceased alive on <b>5-29-1959</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. B. Lyon</b> M.D.		DATE SIGNED <b>5/29/59</b>	
PHYSICIAN'S NAME (Type) <b>I. B. LYON, M.D.</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-31-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>	22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Futo</b> ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

GOVT CERTIFICATE OF DEATH

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## 6110 CERTIFICATE OF DEATH

06099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Smithburg</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Smithburg Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Catherine</u> Last <u>Strite</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> , Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abram H. Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Shank</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louis Strite</u> Address <u>Smithburg Route 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>5 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-23</u> , 19 <u>55</u> , to <u>5-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-30</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.		ADDRESS (Street, city or town, state) <u>Smithsburg Md.</u> DATE SIGNED <u>5-31-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stouffers Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Near Smithburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Mennich</u>		ADDRESS <u>Greencastle, Pa.</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hauer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6078 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>89 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>444 W. Washington St.</b>				d. STREET ADDRESS <b>444 W. Washington</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Emma Jane Strong</b>				4. DATE OF DEATH <b>May 7 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 11, 1870</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Samuel M. Strong</b>				14. MOTHER'S MAIDEN NAME <b>Susan C. Binkley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>---</b>			
INFORMANT <b>Miss Elizabeth Strong Hagerstown Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>							
422.1 DUE TO <b>Arterio-sclerotic Cardio-vascular Disease</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 3</b> , 19 <b>58</b> , to <b>7 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7 May</b> , 19 <b>59</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				DATE SIGNED <b>8 May 59</b>			
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>				M.D. <b>230 N. Potomac St. Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6078

Washington

Married

Washington

Married

89 years

Married

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6079 CERTIFICATE OF DEATH

06101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Jacob</b> Last <b>Stumbaugh</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman Leathersplitter</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Tannery</b>	
11c. BIRTHPLACE (State or foreign country) <b>Near Greencastle Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Jacob Stumbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Jane Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 01 9886</b>	
17. INFORMANT <b>Mr. George Stumbaugh</b>		18. ADDRESS <b>132 Vermont St. Williamsport Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Collapsing Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Day</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3:15 PM</b> to <b>5:15 PM</b> , that I lost saw the deceased alive on <b>3:15 PM</b> , 19 <b>59</b> , and that death occurred at <b>5:15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Robert L. Young</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert L. Young</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 7 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Legg</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



6080 CERTIFICATE OF DEATH

06102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>Rural Hagerstown, Md. R#2</b>			
3. NAME OF DECEASED (Type or print) First <b>GOLDIE</b> Middle <b>MARY</b> Last <b>SWARTZ</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1895</b>		9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Shady Bower, U.S. Route 40 West of Hagerstown.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Frush</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Draper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Harry C. Swartz</b> Address <b>Hagerstown, Md. R#2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION due to Coronary Arteriosclerosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF VULVA WITH METASTASIS - ONEMIA DUE TO BLOOD LOSS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 30, 1958</b> , to <b>MAY 8, 1959</b> , that I last saw the deceased alive on <b>MAY 8, 1959</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D. CLEAR SPRING Md 5-9-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. A. Horst &amp; Sons</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 12 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

MDHS

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2080 CERTIFICATE OF DEATH

1-6-64-10-1

1. PLACE OF DEATH HOME		2. COUNTY BALTIMORE	
3. STREET ADDRESS 1234 E. BALTIMORE AVE.		4. CITY BALTIMORE	
5. STATE MD		6. ZIP CODE 21201	
7. DECEASED'S SEX M		8. DECEASED'S AGE 65	
9. DECEASED'S RACE W		10. DECEASED'S MARITAL STATUS M	
11. DECEASED'S OCCUPATION RETIRED		12. DECEASED'S EDUCATION HS	
13. DECEASED'S BIRTH DATE 01/15/1900		14. DECEASED'S BIRTH PLACE BALTIMORE, MD	
15. DECEASED'S DEATH DATE 01/15/1965		16. DECEASED'S DEATH TIME 10:00 AM	
17. DECEASED'S DEATH PLACE HOME		18. DECEASED'S DEATH CAUSE HEART DISEASE	
19. DECEASED'S DEATH PLACE HOME		20. DECEASED'S DEATH PLACE HOME	
21. DECEASED'S DEATH PLACE HOME		22. DECEASED'S DEATH PLACE HOME	
23. DECEASED'S DEATH PLACE HOME		24. DECEASED'S DEATH PLACE HOME	
25. DECEASED'S DEATH PLACE HOME		26. DECEASED'S DEATH PLACE HOME	
27. DECEASED'S DEATH PLACE HOME		28. DECEASED'S DEATH PLACE HOME	
29. DECEASED'S DEATH PLACE HOME		30. DECEASED'S DEATH PLACE HOME	
31. DECEASED'S DEATH PLACE HOME		32. DECEASED'S DEATH PLACE HOME	
33. DECEASED'S DEATH PLACE HOME		34. DECEASED'S DEATH PLACE HOME	
35. DECEASED'S DEATH PLACE HOME		36. DECEASED'S DEATH PLACE HOME	
37. DECEASED'S DEATH PLACE HOME		38. DECEASED'S DEATH PLACE HOME	
39. DECEASED'S DEATH PLACE HOME		40. DECEASED'S DEATH PLACE HOME	
41. DECEASED'S DEATH PLACE HOME		42. DECEASED'S DEATH PLACE HOME	
43. DECEASED'S DEATH PLACE HOME		44. DECEASED'S DEATH PLACE HOME	
45. DECEASED'S DEATH PLACE HOME		46. DECEASED'S DEATH PLACE HOME	
47. DECEASED'S DEATH PLACE HOME		48. DECEASED'S DEATH PLACE HOME	
49. DECEASED'S DEATH PLACE HOME		50. DECEASED'S DEATH PLACE HOME	
51. DECEASED'S DEATH PLACE HOME		52. DECEASED'S DEATH PLACE HOME	
53. DECEASED'S DEATH PLACE HOME		54. DECEASED'S DEATH PLACE HOME	
55. DECEASED'S DEATH PLACE HOME		56. DECEASED'S DEATH PLACE HOME	
57. DECEASED'S DEATH PLACE HOME		58. DECEASED'S DEATH PLACE HOME	
59. DECEASED'S DEATH PLACE HOME		60. DECEASED'S DEATH PLACE HOME	
61. DECEASED'S DEATH PLACE HOME		62. DECEASED'S DEATH PLACE HOME	
63. DECEASED'S DEATH PLACE HOME		64. DECEASED'S DEATH PLACE HOME	
65. DECEASED'S DEATH PLACE HOME		66. DECEASED'S DEATH PLACE HOME	
67. DECEASED'S DEATH PLACE HOME		68. DECEASED'S DEATH PLACE HOME	
69. DECEASED'S DEATH PLACE HOME		70. DECEASED'S DEATH PLACE HOME	
71. DECEASED'S DEATH PLACE HOME		72. DECEASED'S DEATH PLACE HOME	
73. DECEASED'S DEATH PLACE HOME		74. DECEASED'S DEATH PLACE HOME	
75. DECEASED'S DEATH PLACE HOME		76. DECEASED'S DEATH PLACE HOME	
77. DECEASED'S DEATH PLACE HOME		78. DECEASED'S DEATH PLACE HOME	
79. DECEASED'S DEATH PLACE HOME		80. DECEASED'S DEATH PLACE HOME	
81. DECEASED'S DEATH PLACE HOME		82. DECEASED'S DEATH PLACE HOME	
83. DECEASED'S DEATH PLACE HOME		84. DECEASED'S DEATH PLACE HOME	
85. DECEASED'S DEATH PLACE HOME		86. DECEASED'S DEATH PLACE HOME	
87. DECEASED'S DEATH PLACE HOME		88. DECEASED'S DEATH PLACE HOME	
89. DECEASED'S DEATH PLACE HOME		90. DECEASED'S DEATH PLACE HOME	
91. DECEASED'S DEATH PLACE HOME		92. DECEASED'S DEATH PLACE HOME	
93. DECEASED'S DEATH PLACE HOME		94. DECEASED'S DEATH PLACE HOME	
95. DECEASED'S DEATH PLACE HOME		96. DECEASED'S DEATH PLACE HOME	
97. DECEASED'S DEATH PLACE HOME		98. DECEASED'S DEATH PLACE HOME	
99. DECEASED'S DEATH PLACE HOME		100. DECEASED'S DEATH PLACE HOME	

CERTIFICATE OF DEATH

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland.

## 6111 CERTIFICATE OF DEATH

Reg. Dist. No.

06103

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R. 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PANSY ARBRUTUS SWOPE</u>				4. DATE OF DEATH Month Year <u>MAY-19-1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 25-1903</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM ARNOLD</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE STINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-18-8985</u>		17. INFORMANT <u>LLOYD D. SWOPE</u> Address <u>BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/19/59</u> , 19 <u>59</u> , to <u>5/19/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/19/59</u> , 19 <u>59</u> , and that death occurred at <u>5/19/59</u> , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Dittus III</u> M.D.				ADDRESS (Street, city or town, state) <u>212 W. Washington St</u> DATE SIGNED <u>5/20/59</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Dittus III, M.D.</u>				<u>212 W. Washington St</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>BOONSBORO MD</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
6112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 06104										
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASH.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b>			c. LENGTH OF STAY IN 1b <b>70 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL CLEAR SPRING</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BLAIRS VALLEY ROAD</b>					d. STREET ADDRESS <b>BLAIRS VALLEY ROAD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>M.</b> Last <b>SWORD</b>					4. DATE OF DEATH Month <b>5</b> Day <b>23</b> Year <b>19 59</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 23, 1882</b>		9. AGE (In years last birthday) <b>77</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN SWORD</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE BLAIR</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>FRED SWORD CLEAR SPRING RT 1, MD.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>976X</b> IMMEDIATE CAUSE (a) <b>Gun shot thru skull into brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in forehead with 22 rifle</b>						
20c. TIME OF INJURY Hour <b>6:30</b> a. m. <b>PM</b> Month, Day, Year <b>May 23 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rural Clearspring Wash Md</b>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>S. Robert Wells</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>					DATE SIGNED <b>5-23-59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>			22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b>					ADDRESS <b>CLEAR SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

6081  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

06105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CARROLL CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR WESTMINSTER MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSP</u>		d. STREET ADDRESS <u>06X-2 BACHMAN VALLEY</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>A.</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BACHMAN VALLEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID O. NULL</u>		14. MOTHER'S MAIDEN NAME <u>ANNA A. WIMERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SON DOUGLAS J. THOMAS</u>		Address <u>BIG COVE TANNERY PENNA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT lobular pneumonia, lower lobes, bilateral</u> 583X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of portal vein</u> DUE TO (c) <u>generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 days</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① cerebral atherosclerosis, severe &amp; marked encephalomalacia ② auricular thrombosis ③ old myocardial infarct, rt ventricle ④ pericarditis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 13</u> , 19 <u>57</u> , to <u>May 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>59</u> , and that death occurred at <u>4:14 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Victor L. Ramos</u>		M.D. <u>Western Maryland State Hospital May 13, 1959</u>	
PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/16/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>BACHMAN LUTHERN</u>		22d. LOCATION (City, town, or county) (State) <u>BACHMAN VALLEY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Saffell</u>		ADDRESS <u>254 E. MAIN ST. WESTMINSTER, MD.</u>	
24a. REC'D BY REGISTRAR <u>MAY 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

I, the undersigned, Clerk of the County of \_\_\_\_\_, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the \_\_\_\_\_  
 of \_\_\_\_\_, as the same appears from the records of said County.  
 Given under my hand and the seal of said County, this \_\_\_\_\_ day of \_\_\_\_\_, 1891.  
 \_\_\_\_\_  
 Clerk of the County of \_\_\_\_\_, State of Texas.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

## 6082 CERTIFICATE OF DEATH

Reg. Dist. No.

06106

1. PLACE OF DEATH o. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hosp.</u>		d. STREET ADDRESS <u>1509 Corington St</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille</u> First <u>Trolle</u> Last		4. DATE OF DEATH <u>May 29</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Drydock</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
13. FATHER'S NAME <u>Charles Davis</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Bory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family</u> Address <u>Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Congestion &amp; Edema</u> 962X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subdural empyema subsided</u> DUE TO (c) <u>Acute Subdural Hematoma (Post-op)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>3 mo.</u> <u>4 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abscesses chest wall. Inactive Pulmonary Tuberculosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidental fall in 1953 followed by seizures resulting in fall 4 mo ago</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>4-2</u> 19 <u>59</u> , to <u>5-29</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5-29</u> 19 <u>59</u> , and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>J. B. Lyon</u>		ADDRESS (Street, city or town, state) <u>1500 Henry Van A Ave</u> DATE SIGNED <u>5/29/59</u>	
PHYSICIAN'S NAME (Type) <u>I. B. LYON, M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 2 1959</u>	<u>Reisterstown Meth</u>	<u>Reisterstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGuffey Funeral Homes Balto Md.</u>		24g. REC'D BY REGISTRAR <u>Arthur S. Kenna</u> DATE <u>JUN 1 '59</u>	

1982 CERTIFICATE OF DEATH

00100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6083

## CERTIFICATE OF DEATH

Reg. Dist. No.

06107

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Ernest Trumpower</b>		4. DATE OF DEATH Month Day Year <b>MAY 19 19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9. 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>6 10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leonard L. Trumpower</b>		14. MOTHER'S MAIDEN NAME <b>Martha McCallister</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Ida Trumpower Big Pool Maryland</b>	
17. INFORMANT <b>Ida Trumpower Big Pool Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction due to Coronary Artery Occlusion</b> 420.1 DUE TO Hypertensive arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 12 hours unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 22</b> , 19 <b>58</b> , to <b>May 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 18</b> , 19 <b>59</b> , and that death occurred at <b>12:02A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b> <b>Clear Spring, Maryland</b> <b>May 19, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5.21.59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>St Paul, s Washington Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Howard</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



## 6113 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonesboro</b>		c. LENGTH OF STAY IN 1b <b>2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Reeders Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Idella</b> Last <b>Unger</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Wolfsville Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Hoover</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Oswald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>William E. Unger</b> Address <b>Smithsburg Rt. 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-19-1959</b> , to <b>5-20-1959</b> , that I last saw the deceased alive on <b>5-20-1959</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. Lee Ward</b>		ADDRESS (Street, city or town, state) <b>21 North MAIN ST. BOONSBORO.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>SECONDARI JOSEPH</b>		<b>MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-23-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Smithsburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Smithsburg Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

6084 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06109

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. James Village Rural Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			d. STREET ADDRESS <b>Chapelwood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWIN</b> First <b>LEE</b> Middle <b>WADE</b> Last			4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 9, 1907</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Trego, Maryland</b>		
13. FATHER'S NAME <b>William T. Wade</b>			14. MOTHER'S MAIDEN NAME <b>Lillie V. Gross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-10-5657</b>		17. INFORMANT <b>Mrs. Margaret Wade</b> Address <b>Hagerstown, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>Acute Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Aethma</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>				
20c. TIME OF INJURY Hour a. m. p. m. <b>none</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		
20f. (City or town) <b>-</b>		20g. (County) <b>-</b>		20h. (State) <b>-</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>5-4-59</b>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/5/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		
22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 6 '59</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>						

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
1961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Date of Death		Place of Death	
10-12-57		Washington General Hospital	
Age		Sex	
71		Male	
Race		Color	
White		White	
Marital Status		Cause of Death	
Married		General	
Occupation		Immediate Cause	
Retired		Heart Disease	
Residence		Underlying Cause	
Baltimore, Md		Heart Disease	
Signature of Examiner		Signature of Physician	
[Signature]		[Signature]	
Date of Report		Date of Death	
10-12-57		10-12-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6085 CERTIFICATE OF DEATH

06110

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Nursing Home</b>				d. STREET ADDRESS <b>217 W. Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>BRENNER</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse (RET.)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Falling Waters, W. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles M. Watson</b>				14. MOTHER'S MAIDEN NAME <b>Anna B. Brenner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Earl G. Watson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebro-vascular disease</b> (c) <b>Gen. Arterio Sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>6 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 1, 1959</b> to <b>May 5, 1959</b> , that I last saw the deceased alive on <b>May 5, 1959</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. E. W. Dotto</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr E W Dotto Jr</b>				DATE SIGNED <b>5/8/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/8/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

# 6085 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] MONTHS: [illegible] DAYS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SEX: [illegible]

AGE: [illegible]

PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

NAME OF DECEASED: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06111

## 6114 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clearspring, R # 1</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>MAY</b> Last <b>WILES</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>11</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>near Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Ridenour</b>		14. MOTHER'S MAIDEN NAME <b>---Troupe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Charles Scott Wiles, Clearspring, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Codanody Throm Basis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>1 Day</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/10/59</b> to <b>5/11/59</b> , that I last saw the deceased alive on <b>5/10/59</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington, D.C.</b> DATE SIGNED <b>5/12/59</b> ACTUAL SIGNATURE <b>Paul F. Young</b> M.D. <b>William H. Ford</b> PHYSICIAN'S NAME (Type) <b>Paul F. Young</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Clearspring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

